

67434 OCT-28

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SOPHIE ABARBANEL | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 25 87 | | 2b. HOUR 2 P M | |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 4 22 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | 7b. CITIZEN OF WHAT COUNTRY? U. S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE (CITY) MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. STATE MD | | 13b. COUNTY BALTO | 13c. CITY OR TOWN BALTO | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2500 W. BELVEDERE #21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL WACHS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH RUTH DUBB | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) IF YES, GIVE WAR OR DATES NO | | 16b. SOCIAL SECURITY NO. 416-32-6546A | | 17. INFORMANT MRS. GERALDINE DONALD APT. C-2 6605 PARK HTS. AVE. #21215 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 2 weeks | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHOLECYSTITIS | | | | | | |
| 19a. DATE OF OPERATION 9/16/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLECYSTITIS | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/15/87 19 87 to 9/25 19 87 that (I) (we) last saw the deceased alive on 9/25 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death. | | | | | | |
| 22b. SIGNATURE Kenneth C. Russ | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/25/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH C. RUSS | | 22e. ADDRESS 1806 Thomas St., Baltimore MD 21231 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 27, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Sinden-Rudner | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05434 COL-371

DEC 1 1987

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST <i>Judias Adams</i> | | MONTH DAY YEAR <i>9/30/87</i> | | 8:50 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Female | Black | MONTH DAY YEAR <i>3/24/16</i> | 71 YRS | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Virginia | USA | | <i>Balt City</i> MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | Liberty Medical | | Retired | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2720 Claflin Ct. 21225 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Horace Moore | | n Virginia Moore | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| NO | | 213-18-1425 | Delores Mappdilworth 2720 Claflin Ct (25) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 minutes</i> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Ht. Failure, Renal Failure</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Respiratory Failure</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| <i>9/20/87</i> | | <i>GI bleeding</i> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <i>9/30</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <i>Robert Francis</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | <i>9/30/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| <i>ROBERT FRANCIS</i> | | <i>Liberty Hl. Bldg. Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | 10/3/87 | Arbutus Park | | Arbutus Md. |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Estep Bros. F.H. 1300 Eutaw Pl. | | | <i>OCT 05 1987</i> | | <i>Kevin R. Riddle</i> |

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "John" and "John" are visible.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. The funeral director must complete pages 1 and 2 and should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene permit, no burial, cremation, or transportation of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND | | | | 2 5 3 8 7 | | | |
|---|--|--|--|---|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 2 5 3 8 7 | | | |
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE AIELLO | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 24, 1987 | | 2b. HOUR 9:31 AM | |
| 3. SEX Female | | 4. RACE CAU. | | 5. DATE OF BIRTH MONTH DAY YEAR 7 31 34 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 53 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Postal Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY US Post Office | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN New York N Staten Isl. | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 221 BYRNE AVE 11234 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RAFFAEL D'ADAMO | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARMELA D'ORIO | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (# YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 126-26-9135 | | 17. INFORMANT ADDRESS FRANK AIELLO JR. 221 BYRNE AVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INFECTED HEPATIC NECROSIS DUE TO, OR AS A CONSEQUENCE OF (b) EMBOLIZATION OF MESENTERIC PSEUDOANEURYSM DUE TO, OR AS A CONSEQUENCE OF (c) PANCREATIC CANCER | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs 72 hrs 10 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a BILIARY FISTULA | | | | | | | |
| 19a. DATE OF OPERATION ① 8/17/87 ② 9/23/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ① ADENOCARCINOMA OF PANCREAS ② INFECTED HEPATIC NECROSIS | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG 16 , 19 87 , to SEPT 24 , 19 87 , that (I) (we) last saw the deceased alive on SEPT. 24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Mark S. Schnitzer | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK S. SCHNITZER | | | | 22e. ADDRESS JHH | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY ST. Peter's Cem. Staten Island | | 23d. LOCATION CITY OR TOWN COUNTY STATE New York | |
| 24. FUNERAL DIRECTOR NAME Donald J. Hall | | | | 25a. DATE REC'D. BY REGISTRAR 10-7-87 | | 25b. REGISTRAR'S SIGNATURE | |

65759 SEP 16 87

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25388
2a. DATE OF DEATH MONTH DAY YEAR 9 9 87 2b. HOUR 4:43 PM

1. DECEASED NAME FIRST MIDDLE LAST Harry Joseph Alascio

3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 8 26 11 6. AGE (IN YEARS (LAST BIRTHDAY)) 76 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH BALTIMORE 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FREIGHT HANDLER 12b. KIND OF BUSINESS OR INDUSTRY TRUCKING

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND 13c. COUNTY --- 13d. CITY OR TOWN BALTIMORE 13e. INSIDE CITY LIMITS? YES ☒ NO ☐ 13f. STREET ADDRESS 4602 PARKTON STREET 21229

14. FATHER'S NAME FIRST MIDDLE LAST ROSARIO ALASCIO 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE CASIO

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES 16b. SOCIAL SECURITY NO. WW II 216-12-5914 17. INFORMANT ADDRESS BALTO. MD 21207 HARRY C. ALASCIO 1501 CANTWELL ROAD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio pulmonary arrest
(b) acute myocardial infarction
(c) Corning heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes Mellitus

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.D. 22e. ADDRESS ST. AGNES HOSPITAL, BALTIMORE, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 9/12/87 23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND

24. FUNERAL DIRECTOR NAME PERRY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE, MD 21228 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

825 23 23 19 14

65756 SEP 16 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|---------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Alder | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/8/87 | | 2b. HOUR 11⁰⁰ PM | | |
| 3. SEX ♀ | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 5/9/17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter James Collins | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna May Johnson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 212-07-1848A | |
| 17. INFORMANT ADDRESS Vivian Warren 3024 Remington Ave. 21211 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) massive Brainstem Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) 6-9 hrs | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (we) attended the deceased from Sept 8, 1987 to Sept 8, 1987 , that (I) (we) saw the deceased alive on Sept 8, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Edwin B George | | DEGREE MD, PhD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin B George | | 22e. ADDRESS Sinai Hosp | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | 25a. DATE REC'D BY REGISTRAR SEP 14 1987 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

18 61 922 02 7 52

067534 OCT 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25390

| | | | | | | | | | | | |
|---|--|--|---|--|-------------------------------|---|--|--|--|---------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Albert</u> MIDDLE: LAST: <u>Alexander</u> | | | 2a. DATE OF DEATH MONTH: <u>9</u> DAY: <u>22</u> YEAR: <u>1987</u> | | 2b. HOUR <u>8:22 P.</u> M. | | | | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>Black</u> | | 5. DATE OF BIRTH MONTH: <u>3</u> DAY: <u>12</u> YEAR: <u>1921</u> | | 6. AGE (IN YEARS (LAST BIRTHDAY)) <u>66</u> YRS. | | IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN. | | IF UNDER 24 HRS. HOURS: MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>UNK.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>BON SECOURS HOSPITAL</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Seaman</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Maritime</u> | | | |
| 13a. STATE <u>MD.</u> | | 13b. COUNTY <u>BALTIMORE</u> | | 13c. CITY OR TOWN <u>BALTIMORE</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <u>662 PITCHER STREET 21217</u> | | | |
| 14. FATHER'S NAME FIRST: <u>Albert</u> MIDDLE: LAST: <u>Alexander</u> | | 15. MOTHER'S MAIDEN NAME FIRST: <u>Lillian</u> MIDDLE: LAST: <u>Jones</u> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>UNK.</u> | | 16b. SOCIAL SECURITY NO. <u>220-09-5594</u> | | 17. INFORMANT ADDRESS: <u>BARBARA ALEXANDER - daughter 406 CATEHEAD</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction 1 day</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/15/87</u> 19 to <u>9/22/87</u> 19 that (I) (we) lost saw the deceased alive on <u>9/22/87</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>S. S. DANG</u> | | DEGREE <u>M.D.</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>9/25/87</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. S. DANG</u> | | 22e. ADDRESS <u>40 S. Dundalk Ave Balto Md 21222</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>10-02-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>James A. Moore</u> | | 25a. DATE REC'D. BY REGISTRAR <u>OCT 1 1987</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julia Dondyk-Rudner</u> | | | | | | | |

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066540 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25391

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALEXANDER, NMT | | MIDDLE KEIFER | | 2a. DATE OF DEATH MONTH DAY YEAR 09 18 87 | | 2b. HOUR 7²⁵ A.M. | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 05 09 32 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALT CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MARYLAND HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 13a. STATE MD | | 13b. COUNTY BALT CITY | | 13c. CITY OR TOWN BALT CITY | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GUY Alexander | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCY James | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 213-28-8277 | |
| 17. INFORMANT Elizabeth Botts | | ADDRESS 252 Robert Street | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Cessation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/17/87 , 19 87 , to 9/18/87 , 19 87 that (I) (we) last saw the deceased alive on 9/18/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE D. Pichney MD | | | | DEGREE MD | | 22c. DATE SIGNED 9/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PICHNEY MD | | | | 22e. ADDRESS 22. S. Greene St. BALT MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/23/87 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE I ANSDOWNF, MD | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. | | | | ADDRESS 1101 E. NORTH AVENUE | | 25a. DATE REC'D BY REGISTRAR SEP 22 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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BP

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SEP 23 07

067578 OCT - 5 67

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 5 3 9 2

REG. NO.

| | | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) LATIMER BRECK ALEXANDER | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 29 87 | | | 2b. HOUR 9:50A M | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 19 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist | | 12b. KIND OF BUSINESS OR INDUSTRY Pharmacy-Proprietor | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Relay | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1105 Francis Avenue 21227 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Latimer Breck Alexander, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Elizabeth Rankin | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 215-05-0013 | |
| 17. INFORMANT ADDRESS 21227 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HISTORY OF OLD CEREBRAL VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>HYPOTHERMIA - 89°F ON ADMISSION</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>James E. Taylor</u> | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. TAYLOR | | | | | | 22e. ADDRESS ST. AGNES HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/1/87 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT - 2 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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BP

064809 SEP-4-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25393

1. FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Anna

Allbritton

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

9 2 87

10 p.m.

3. SEX

F

4. RACE

W

5. DATE OF BIRTH

MONTH

DAY

YEAR

9 23 00

6. AGE (IN YEARS LAST BIRTHDAY)

86

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

City

MD.

10. CITY OR TOWN OF DEATH

Balto.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

1532 La Porte Tr / 21230

14. FATHER'S NAME

FIRST
Rost

MIDDLE

LAST
John

15. MOTHER'S MAIDEN NAME

FIRST
Beatrice

MIDDLE

LAST
Taylor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

unk

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

215034976

17. INFORMANT

Roberta

ADDRESS

374 71146

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

SPECULATE INTERVAL
BETWEEN CAUSE AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulm. arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Aspirational pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c) Metastatic colon cancer, breast Ca

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

above, (b) (we) did not view the body after death

19 87 to 9/2 87

and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

ATTENDING

MEDICAL

STAFF

PHYSICIAN ☐DIRECTOR ☐PHYSICIAN ☒

22c. DATE SIGNED

9/2/87

22d. PHYSICIANS NAME (TYPE OR PRINT)

CHENG, WAI - FUNG

22e. ADDRESS

South Baltimore General Hosp

3001 S. Hanover St. Balto. MD 21230

23a. BURIAL, CREMATION, REMOVAL

(IFY)

Burial

23b. DATE

9/5/87

23c. NAME OF CEMETERY OR CREMATORY

Glen Haven Cem. Glen Burnie Md

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Charles L. Sterens

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

SEP 3 1987 Julia Davidson-Randall

26. DATE OF DEATH

27. REGISTRAR'S SIGNATURE

28. REGISTRAR'S SIGNATURE

29. REGISTRAR'S SIGNATURE

30. REGISTRAR'S SIGNATURE

31. REGISTRAR'S SIGNATURE

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067167 SEP 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 25394 | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED MIDDLE ALMONY LAST | | | | | 2a. DATE OF DEATH MONTH 9 DAY 28 YEAR 87 | | | 2b. HOUR 10:30 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 11 DAY 17 YEAR 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST Fred MIDDLE LAST Wells | | | | | 15. MOTHER'S MAIDEN NAME FIRST Emaline MIDDLE LAST Wells | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17. INFORMANT Donna Pittinger 3447 Ebenezer Rd. 21047 | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) ENDOMETRIAL CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/24 19 87, to 9/28 19 87, that (I) (we) lost saw the deceased alive on 9/28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE A.C. Chevalier, M.D. | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/28/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. CHEVALIER, M.D. | | | | | 22e. ADDRESS NORTH CHARLES GEN. HOSP. 21218 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/30/87 | | 23c. NAME OF CEMETERY OR CREMATORY Fosters Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Monkton Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. 3818 Roland Avenue 21211 ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR 9-30-87 | | 25b. REGISTRAR'S SIGNATURE | | | | |

2010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Kathleen B. ALSTON | | | 2a. DATE OF DEATH MONTH 9 DAY 7 YEAR 87 | | | 2b. HOUR 11:50 AM | | | | |
| 3. SEX F | | 4. RACE (M) Black | | 5. DATE OF BIRTH MONTH 3 DAY 10 YEAR 99 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST R. W. MIDDLE LAST Ketchum | | | 15. MOTHER'S MAIDEN NAME FIRST Amanda MIDDLE LAST Waters | | | 13e. STREET ADDRESS / ZIP CODE 3714 Sequoia AVE 21215 | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 218-10-6595 | | 17. INFORMANT Helen Alston | | ADDRESS 3714 Sequoia Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension non ketotic com DUE TO, OR AS A CONSEQUENCE OF (c) New CVA due to atherosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-20-87 , to 9-7-87 , that (I) (we) last saw the deceased alive on 9-7-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9-10-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. S. NAIR, MD | | | 22e. ADDRESS 5010 York Road Baltimore, MD 21212 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H West ADDRESS 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please provide carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) CROXTON, L. ALVIN | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 25 87 | | 2b. HOUR 538 PM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 01 11 29 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Handler Post Office | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ASHLAND CROXTON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA ELLIOTT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes. | |
| 16b. SOCIAL SECURITY NO. 1951-1953 020-20-5589 | | 17. INFORMANT Mrs. Eunice Croxton | | ADDRESS 5362 Carriage Ct | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that at this hospital attended the deceased from 09/14/87, 19 87, to 09/25, 19 87, that I saw the deceased alive on 09/25/87, and that in my opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE J. Croxton MD | | DEGREE | | 22c. DATE SIGNED 09/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Croxton | | 22e. ADDRESS 3001 S. Hanover St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial | | 23b. DATE 10-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest U.S. Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CO. MD | | 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1987 | |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandora | | | | | |

087523 OCT-1-87

LIBER

LIBER

SEP 29 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Thomas | | P. | | AMRHIE | | | | 9/3/87 | | 2:50 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 73 HRS HOURS MIN. | |
| Male | | White | | March 9 1911 | | 76 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | Union Memorial Hospital | | Ret. State of Md | | Audit | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Maryland | | | | Baltimore | | | | 1806 Northbourne | | 21239 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Phillip | | Lillian | | Christensen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 216-03-9613 | | Kenneth Gegner | | 5321 Plainfield Ave 21206 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 hr</u> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Probable Metastatic Bladder Cancer</u> | | | | | | | | | | <u>5 yr</u> | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> 19 <u>87</u> to <u>9/3</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Wendie A. Bay MD</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>9/3/87</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wendie A. Bay MD | | | | | | 22e. ADDRESS 201 University Parkway | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | Sept. 5 1987 | | Gardens of Faith | | Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Leonard J. Ruck Inc. 5305 Harford Rd. | | | | | | SEP 04 1987 | | <u>Edna Davidson-Randall</u> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please send pages 3 and 4 to the State Department of Health and Mental Hygiene, 201 W. Preston St., Baltimore, Maryland 21201. IMPORTANT: If item 21 is marked as "not at work" or "not at home", the medical examiner must be notified and a separate certificate filed.

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RECEIVED

NOTED

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Special

Library

Library of Congress

2003

065083 SEP-9 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Lee Anderson | | | 2a. DATE OF DEATH MONTH DAY YEAR September 3, 1987 | | 2b. HOUR 1018 P M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 12, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | 13b. COUNTY A A Co. | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 115 Garrett Road 21061 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Farris | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie M. Kidwell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA | 17. INFORMANT James T. Gross | | ADDRESS 269 Laguna Circle Severna Park, Md. 21144 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac tamponade</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute inferior myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/2</u> 19 <u>87</u> , to <u>9/3</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert R. Ramirez | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/3/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMIREZ ROBERT R | | 22e. ADDRESS 3001 S. Hanover St. Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Sept 8, 1987 | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Maryland | | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home | | ADDRESS Glen Burnie, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1987 | 25b. REGISTRAR'S SIGNATURE J. Anderson-Randall |

MEDICAL CERTIFICATION

BP



065487 SEP 15 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25399

FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LEE

C.

ANDERSON, SR.

2a. DATE OF DEATH

MONTH

DAY

YEAR

9 11 87

2b. HOUR

05:50 M

3. SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

9 21 22

6. AGE (IN YEARS LAST BIRTHDAY)

64

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

NEBRASKA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

St Agnes Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Data Processing Mortgage Board

12b. KIND OF BUSINESS OR INDUSTRY

Federal

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Lansdowne

13d. INSIDE CITY LIMITS?

YES

NO

13e. STREET ADDRESS

1722 Wilson Avenue 21227

14. FATHER'S NAME

Bowers

MIDDLE

LAST

Anderson

15. MOTHER'S MAIDEN NAME

Effie

MIDDLE

LAST

Coleman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

WW II

17. INFORMANT

215-12-2910

ADDRESS

Robert D. Anderson 3145 Ryerson Circle 21227

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Vent anystole

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Acute pulm edema, severe CHF

DUE TO, OR AS A CONSEQUENCE OF

(c) Acute MI

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES

NO

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?

YES

NO

21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/1/87, 1987, to 9/11/87, 1987, that (I) (we) lost
saw the deceased alive on 9/11/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c. DATE SIGNED

9/11/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

NITIN MAYUR

22e. ADDRESS

AT Agnes Hospital

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

9/14/87

23c. NAME OF CEMETERY OR CREMATORY

Meadowridge Mem. pk.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Elkridge

Howard Maryland

24. FUNERAL DIRECTOR

NAME

Hubbard Funeral Home, Inc. 4107 Wilkens Ave.

ADDRESS

21229

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

SEP 14 1987

Julia Tindler-Randall

002403 SEP 12 81

SEP 14 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove containing pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 5 Film 6631 9-10-87
FOR
1- STATE per Funeral Home SB
REGISTRAR **Thomas Anello**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

65319 SEP 14 87

| | | | | |
|---|--|---|---|--|
| DECEASED NAME (TYPE OR PRINT) Thomas Anello | | 2a. DATE OF DEATH MONTH DAY YEAR 9-9-87 | | 2b. HOUR 12:15 PM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7-14-1913 2-13-21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven VAH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR 12 MONTHS PREVIOUS TO DEATH) Sanitation Worker | 12b. KIND OF BUSINESS OR INDUSTRY Balto. City |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Essex | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Salvatore L. Anello | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosietta ? | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-14-6668 | | 17. INFORMANT Thomas Anello Baltimore Maryland 21221 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypoxia DUE TO, OR AS A CONSEQUENCE OF (c) terminal metastatic lung CA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 years | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: hx MI, hx CABG x4, DM, PUD | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/7/87 19 87 , to 9/9 19 87 , that (I) (we) lost saw the deceased alive on 9/7 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Renee E. Corley MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/9/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Renee E. Corley M.D. | | 22e. ADDRESS — | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/12/87 | 23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery | |
| 23d. LOCATION (CITY OR TOWN) COUNTY STATE Crownsville, Md. | | 23e. DATE RECD. BY REGISTRAR SEP 10 1987 | | |
| 24. FUNERAL DIRECTOR Brazdzinski Funeral Home | | 25a. DATE RECD. BY REGISTRAR SEP 10 1987 | | |
| 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall | | 25c. REGISTRAR'S SIGNATURE — | | |

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62310 SEP 14 87

• House Bill •

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LEGISLATIVE COUNCIL

— — —

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25401

067582 OCT 5 1987

| | | | | | |
|---|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME (LAST, FIRST, MIDDLE) Theodore J. Angelus | | 2a. DATE OF DEATH MONTH DAY YEAR 9 30 87 | | 2b. HOUR 545 ^(A) M | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 15 1884 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 103 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. - Restaurant | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4409 Loch Raven Blvd. 21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Angelus | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO 218-18-6046 | | 17. INFORMANT ADDRESS Mrs. Katherine Doonis Same as #13e | |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>CONGESTIVE HEART FAILURE</u> 6 years DUE TO, OR AS A CONSEQUENCE OF } (c) <u>CHRONIC RENAL FAILURE</u> 6 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>NONE</u> | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> , 19 <u>87</u> , to <u>9/30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Richard J. Tarran</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9-30-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD J. TARRAN | | 22e. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 10-1-87 | 23c. NAME OF CEMETERY OR CREMATORY Greek Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore, Md. | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland | | 25. DATE REC'D. BY REGISTRAR OCT - 2 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Tindon-Randall</i> | |

067505 001-205

065086 SEP 9 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25402

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET SARAH ANTHONY | | | 2a. DATE OF DEATH MONTH DAY YEAR September 5, 1987 | | 2b. HOUR 2:55 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR October 17, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa St. Michael Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | 13c. CITY OR TOWN Severn | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1914 Foxhound Ct. 21144 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hiram Garber | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Sarah Burnfield | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | (IF YES, GIVE WAR OR DATES) N/A | 16b. SOCIAL SECURITY NO. 302-46-8930 | 17. INFORMANT (Son) Mr. Gerald T. Anthony, Sr. | | Same as # 13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>PARKINSONS DISEASE; C.O.P.D.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Tasneem Lakhani</u> | | DEGREE MD | | 22c. DATE SIGNED 9/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Tasneem Lakhani | | 22e. ADDRESS 722 Park Heights Ave. Baltimore, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 9, 1987 | 23c. NAME OF CEMETERY OR CREMATORY Greene County Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Waynesburg Greene PA |
| 24. FUNERAL DIRECTOR NAME <u>R. A. Singleton</u> ADDRESS Singleton Funeral Home, Glen Burnie, Maryland | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pandora</u> |

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon plate from page 3 and 4 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, show the injury, or other traumatic event, including circumstances, in the medical record.

002080 SEP-09

80% COTTON FIBER



WATFORD



066121 SEP 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25403

| | | | | | | | | | |
|--|--|--|--|--|---|---|------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANNA MAY ANTILITZ | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-16-87 | | | 2b. HOUR 0240 M | | | |
| 3. SEX F | | 4. RACE caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 5 16 32 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of MD Hospital (MIEMS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WEEK END) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1131 Hull St. 21230 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John T. Antilitz | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Berth Harrington | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 216-28-6981 | | 17. INFORMANT Suzanne Antilitz | | ADDRESS 1131 Hull St. 21230 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intercutaneous fistula DUE TO, OR AS A CONSEQUENCE OF (c) Necrotizing fasciitis | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus, candidemia, | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/8/87 1987 to 9/16/87 1987, that (I) (we) lost saw the deceased alive on 5/16/87 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Virendra K Saxena | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIRENDRA K SAXENA | | | | | | 22e. ADDRESS M.I.E.M.S.S. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Ridge Cemetery | | 23d. LOCATION 15th St. Apt. 404 | | |
| 24. FUNERAL DIRECTOR Charles L. Shivers Funeral Home Inc. | | | | | | 25. DATE REC'D. BY REGISTRAR SEP 17 1987 | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

066791 SEP 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOLORES MARIE ANTKOWIAK | | | 2a. DATE OF DEATH MONTH DAY YEAR September 23 1987 | | 2b. HOUR 1 50 A M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH September 28 1930 | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOS. APTA | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS) Clerical | | 12b. KIND OF BUSINESS OR INDUSTRY State of Md |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Glen Burnie | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 312 Highland Dr. / 21061 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST IRVIN Elmer McCauley | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEPHINE CHESTER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | 17. INFORMANT (Son) ADDRESS David Antkowiak 317 Stevens Ave Arnold, Md 21012 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>STAPHYLOCOCCUS SEPTICEMIA</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>MALNUTRITION, ALCOHOL ABUSE, GI Bleeding.</u> | | | | | |
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY N/A HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED N/A WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-8, 19 87, to 9-22, 19 87, that (I) (we) last saw the deceased alive on 9-22, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert R. Ramirez | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/22/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT R. RAMIREZ | | 22e. ADDRESS 3001 S. HANOVER ST. BALTIMORE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Sept 25 1987 | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery Baltimore | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Md. 21061 | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Item placed in the casket. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068501 269 5261

LIBRARY
OF THE
U.S. DEPARTMENT OF
COMMERCE
WASHINGTON, D.C.

67252 SEP 30

Item 13a per phone - Hosp
 FOR STATE REGISTRAR 9/30/87 DAD
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

25405

| | | | | | |
|--|--|--|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) BABY BOY ANYANWU | | | 2a DATE OF DEATH MONTH DAY YEAR SEPTEMBER 18, 1987 | | 2b HOUR 9:39PM |
| 3 SEX MALE | 4 RACE BLACK | 5 DATE OF BIRTH MONTH DAY YEAR 07/06/1987 | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 2 12 | IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Garland Ave 21236 | 12b KIND OF BUSINESS OR INDUSTRY 5500 GOODNOW ROAD 21206 | |
| 13a STATE MARYLAND | | | 13b COUNTY BALTO. | 13c CITY OR TOWN BALTIMORE | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST LONGINUS ANYANWU | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH IKEONWU | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | 17 INFORMANT ADDRESS EDITH ANYANWU ABOVE | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Neonatal Meningitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>2 months</u> | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Respiratory Failure</u> | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>07/06</u> , 19 <u>87</u> , to <u>09/18</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>09/18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>Andrew V. Allen</u> | | DEGREE <u>M.D.</u> | | 22c DATE SIGNED <u>9/19/87</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Andrew V. Allen</u> | | 22e ADDRESS <u>Dept. Pediatrics, J.H.H.</u> 600 N WOLFE ST. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u> | | 23b DATE <u>9-24-87</u> | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE |
| 24 FUNERAL DIRECTOR <u>State Anatomy Board</u> | | | 25a BY FEE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE <u>SEP 28 1987</u> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

067311 OCT -1 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25406

REG. NO.

| | | | | | | | |
|---|-------------------------------------|---|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Benjamin J. Arbutus | | | 2a. DATE OF DEATH MONTH DAY YEAR September 28, 1987 | | | 2b. HOUR 10:30 P.M. | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 25, 1925 | 6. AGE (IN YEARS LAST BIRTHDAY) 62 | | 7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | 10. CITY OR TOWN OF DEATH Baltimore | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1109 S. Bonsal St. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe fitter Sparrows Point | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Urbutis | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Kupaeinskitie | | 16. ADDRESS 1109 S. Bonsal St. 21224 | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II | | | 17b. SOCIAL SECURITY NO. 219-10-4217 | | 17c. INFORMANT Josephine V. Arbutus 1109 S. Bonsal St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic CA. Lung.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| None. | | | | | | | |
| 9a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1987, to Sept 28, 1987, that (we) last saw the deceased alive on Sept 13, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE Gregory Kelly MD | | | | 22c. DATE SIGNED Sept 28, 1987 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory Kelly MD | | | | 22e. ADDRESS Greater Dundalk Medical Center 2112 Dundalk Ave. Balt, Md 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-1-87 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk | | 24b. ADDRESS 7922 Wise Ave. Dundalk, MD 21222 | | 24c. DATE REC'D. BY REGISTRAR SEP 30 1987 | | 24d. REGISTRAR'S SIGNATURE Julia Dison-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as illegal, it shows any injury, or other traumatic event, the medical examiner must be notified at once.



065158 SEP 10 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25407

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | |
|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT Ernest ARMOUR | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 4, 1987 | | 2b. HOUR 7:16A M |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH. MONTH DAY YEAR 10 - 27 - 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) G.A. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR | 12b. KIND OF BUSINESS OR INDUSTRY |

| | | | | | |
|--|--|---|-----------------------------|--|---|
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE M.D. | | 13b. COUNTY | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1807 Rutland Ave #212/3 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Armour | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Lena Bryant | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO | |
| 16b. SOCIAL SECURITY NO. 244-14-2816 | | 17. INFORMANT ADDRESS Helen Armour 1807 Rutland Ave #212/3 | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1' |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOGENIC SHOCK</u> | | 30' |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTHRITIS WITH MYOCARDIAL INFARCTION</u> | | 12" |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

LEFT HEMISPHERIC CEREBROVASCULAR ACCIDENT, CHRONIC RENAL FAILURE

| | | | |
|--|---|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (1) this hospital attended the deceased from AUG 19, 19 87, to SEPT 4, 19 87, that (1) we last saw the deceased alive on SEPT 4, 19 87, and that if (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death.

| | | | |
|--|--------------|---|----------------------------|
| 22b. SIGNATURE Rob Reimer | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 9/4/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROB REIMER MD | | 22e. ADDRESS JOHNS HOPKINS HOSPITAL 21204 507 N WOLFE ST BALTIMORE MD | |

| | | | |
|--|---------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE 9/9/87 | 23c. NAME OF CEMETERY OR CREMATORY BALTO. Cem | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. |
| 24. FUNERAL DIRECTOR Name Address Bett's Funeral Home 1129 N. Caroline | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1987 | 25b. REGISTRAR'S SIGNATURE [Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The 16a requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove carbon copies. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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ALBANY
SEP 10 1981

66544 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25408

REG. NO.

| | | | | | | |
|--|--|--|--|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LONNIE ARMSTRONG NMT | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 19 87 | | 2b. HOUR 11 P.M. | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 03 22 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UMMS | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY Construction |
| 13a. STATE MD | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN CITY | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES Y ARMSTRONG | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SINNA NMT NELSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 212 30 1706 |
| 17a. DATE OF OPERATION | | 17b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>87</u> , to <u>9/19</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>9/19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE J. M. KLEMAN | | 22c. ADDRESS UMMS 22 S. GREENE ST BALTO. 21201 | | 22d. DATE SIGNED 9/19/87 |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-24-87 | | 23c. NAME OF CEMETERY OR CREMATORY King Mem Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD |
| 24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons | | ADDRESS 1701 Laurens | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Decker-Kendall |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIOPULMONARY ARRESTAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**1 HOUR**

DUE TO, OR AS A CONSEQUENCE OF

(b)

NOCARDIA PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c)

LUNG MASS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHITE ☐ NOT WHITE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/10, 19 87, to 9/19, 19 87, that (I) (we) lost saw the deceased alive on 9/19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☒

22d. DATE SIGNED

22c. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Jas. A. Morton & Sons**1701 Laurens****SEP 22 1987****Julia Decker-Kendall**

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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J67537 OCT-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 25409

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joseph ARNOLD | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 28 87 | | | 2b. HOUR 10:43 P M | | | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 01 02 35 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Carpeting | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1917 BRADY AVE. 21227 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES N. ARNOLD | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHRYN HASTINGS | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN | | | | 16b. SOCIAL SECURITY NO. 215-30-9328 | |
| 17. INFORMANT Mrs. Carolyn Arnold | | | ADDRESS 1917 Brady Ave | | | 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>SMALL CELL CARCINOMA of Lung</u> 4 months | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 17</u> , 19 <u>87</u> , to <u>Sept 28</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Sept. 28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Nick F. Musso, MD</u> | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nick F. Musso, MD | | | | | | 22e. ADDRESS 3001 S. HANOVER ST. Baltimore MD 21230 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/02/87 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Ambrose Funeral Home | | | | | | ADDRESS 1328 Sulphur Spring Road | | 25a. DATE REC'D. BY REGISTRAR OCT 29 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Tidmore-Pandora | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It must be signed by the funeral director, and must be accompanied by the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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25410
REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|--|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH | YEAR | 2b. HOUR |
| ELEASE | | L. | | ARRINGTON | | 9 | 24 | 87 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR |
| F | | B | | MONTH 6 DAY 22 YEAR 11 | | 76 | | IF UNDER 24 HRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MD. | | U.S.A. | | | | BALTIMORE CITY | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | | 1731 LINDEN AVE. | | | | UNK. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS |
| MD. | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1731 LINDEN AVE. |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | |
| LOUIS VANLANDINGHAM | | | | ALICE VINSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | 212-16-3522 | | ELAINE FONTAIN - daughter | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST, PROBABLE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ALZHEIMER'S DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 MINUTE</u> <u>2 YEARS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>—</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| — | | — | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | P.M. 19 | | — | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | — | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/21/87</u> , 19 <u>87</u> , to <u>9/24/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/21/87</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Sheldon Amzel</u> DEGREE | | | | | | 22c. DATE SIGNED <u>9/29/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S AMSEL</u> | | | | | | 22e. ADDRESS <u>22 Greene St Balt Md 21207</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Removal | | 9-24-87 | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. DATE RECEIVED BY RACIAL AUTHORITY | | 25b. REGISTRAR'S SIGNATURE |
| State Anatomy Board | | | | Balto, Md. | | OCT 07 1987 | | <u>Julia Davidson</u> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BF

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STATION 1 STATION 2 STATION 3 STATION 4
 ROAD 1 ROAD 2 ROAD 3 ROAD 4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRATION

085992 SEP 17 1987

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Dorothy L. Ashley

2a. DATE OF DEATH MONTH DAY YEAR
9-6-87

2b. HOUR
6 PM

3. SEX
F

4. RACE
White

5. DATE OF BIRTH MONTH DAY YEAR
3-6-42

6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.
45

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
So. Balt. Gen. Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Music Teacher

12b. KIND OF BUSINESS OR INDUSTRY
Education

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN
MD. Baltimore Baltimore

13b. INSIDE CITY LIMITS? YES ☒ NO ☐

13c. STREET ADDRESS / ZIP CODE
7734 Washington Blvd. 21238

14. FATHER'S NAME FIRST MIDDLE LAST
Joseph Ashley

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lillian Markley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
unknown

16b. SOCIAL SECURITY NO.
22 0381590

17. INFORMANT ADDRESS
R. Wudrick 3001 S. Hanover St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Resp. Failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

Obesity hyperventilation Syndrome

DUE TO, OR AS A CONSEQUENCE OF

(c)

COPD

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-6-87 to 9-6-87, that (I) (we) lost
saw the deceased alive on 9-6-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE
R. Wudrick

DEGREE
MD.

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED
9-6-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. WUDRICK

22e. ADDRESS
3001 S. Hanover St. Balt., MD 21230

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL

23b. DATE
SEPT 9 1987

23c. NAME OF CEMETERY OR CREMATORY
UNION CEMETERY

23d. LOCATION CITY OR TOWN COUNTY STATE
BARTONSVILLE MD

24. FUNERAL DIRECTOR NAME ADDRESS
DONALDSON Funeral Home Laurel, Md.

25a. DATE REC'D BY REGISTRAR
SEP 14 1987

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete and return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

082200Z SEP 17 01



165010 SEP-987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25412

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joseph Lawrence | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-7-87 | | | 2b. HOUR 5:30 AM | | |
| 3. SEX MALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH MONTH DAY YEAR 6 22 1900 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 | | |
| 10. CITY OR TOWN OF DEATH BALTO | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Joseph Richey House 830 Eutaw St | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | | |
| 13a. STATE MD | | | 13b. COUNTY | | | 13c. CITY OR TOWN BALTO | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Peter Bach | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Johanna Hussey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. N/A | | | 17. INFORMANT ADDRESS Elizabeth M Bach 29 Kingsley Rd 21117 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1c. | | | | | | | | |
| 19a. DATE OF OPERATION N/A | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK N/A | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-7-87, to 9-7-87, that (I) (we) last saw the deceased alive on 9-7-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Michael S. Hayes, M.D. | | | | | | 22c. DATE SIGNED 9-7-87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Hayes, MD |
| 22e. ADDRESS 827 Linden Ave. 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept 10, 1987 | | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem | | |
| 23d. LOCATION (CITY OR TOWN) COUNTY STATE Baltimore Maryland | | | 24. FUNERAL DIRECTOR NAME ADDRESS Eckhardt Funeral Chapel 21117 | | | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 08 1987 | | | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodden | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

182010 SEP-30

BACH

SEP 30 1960

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25413

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Frederick B. Bahr | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 12 87 | | | 2b. HOUR 9:00AM | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH 9-30-1921 YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 yrs. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber | | 12b. KIND OF BUSINESS OR INDUSTRY Self-Employ | |

| | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 3220 Belair Road 21213 | | |
| 14. FATHER'S NAME Frederick Bahr | | | | | | 15. MOTHER'S MAIDEN NAME Gustella Wagner | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO. WWII 230-22-3456 | | | 17. INFORMANT James Michael | | | ADDRESS 21213 3220 Belair Road | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) <u>metastatic lung cancer</u> years | |
| (c) | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: N.A.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION <u>N.A.</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N.A.</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <u>N.A.</u> | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.) <u>N.A.</u> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>N.A.</u> | | | |

22. I certify that (I) (this hospital) attended the deceased from Sept 16 1987 to Sept 17 1987, that (I) (we) lost
saw the deceased alive on Sept 17 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

| | | | | | | | | |
|--|--|--|---|--|--|-----------------------------|--|--|
| 22b. SIGNATURE <u>Cara L. Davis</u> | | | DEGREE | | | 22c. DATE SIGNED 9/17/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cara L. Davis, M.D. | | | 22e. ADDRESS The Union Memorial Hospital | | | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-19-87 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forrest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md. | |
|--|--|----------------------|--|--|--|---|--|

| | | | | | | |
|--|--|--|--|--|---|--|
| 24. FUNERAL DIRECTOR Schulz Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randner</u> | |
|--|--|--|--|--|---|--|

MEDICAL CERTIFICATION

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove confidential pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of once.

066172 SEP 18 61

20% COTTON 18261

SEP 18 1961

066907 SEP 28 1987

OR Items 8.16a Film G632

STATE 10-1-87 Marr. Cert. Discharge Papers SB
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25414

| | | | | | | | | | | | | | | | | | |
|--|---------|---|--|---|--|---|--|-------------------------------------|--|----------------------------------|--|---|--|------|--|-----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| ELMORE | | L. | | | | BAILEY | | <input checked="" type="checkbox"/> | | 9 | | 22 | | 1987 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| M | B | MONTH 3 DAY 31 YEAR 19 | | LAST BIRTHDAY 58 YRS. | | MONTHS DAYS | | HOURS MIN. | | 9 | | 22 | | 1987 | | 4:44 A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| VA | | U.S.A. | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore City | | MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 2409 Baker St. | | POSTAL WORKER | | FED. GOVT. | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE (CITY LIMITS?) | | 13e. STREET ADDRESS | | | | | | | | | |
| MD | | | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 539 N. LONGWOOD STREET 21223 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| JOHN | | MARY | | NO | | 217-05-1940 | | LEWIS | | BAILEY 1829 N. WASHINGTON STREET | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) | | Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | (b) | | | | | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | |
| Diabetes mellitus | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| | | Deputy Chief | | 9-22-87 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Penn St., Balto., MD | | 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| BURIAL | | 9/28/87 | | BALTIMORE NATIONAL CEM. | | BALTIMORE | | | | | | MD | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| NAME | | ADDRESS | | | | | | | | | | | | | | | |
| WM. C. MARCH F/H, INC. | | 1101 E. NORTH AVENUE | | SEP 25 1987 | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #1A.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH: 17
(VR A15 ME (5))

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REBA NOTION 2000

WIKI-FISH

067362 OCT-18

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25415

REG. NO.

| | | | | | |
|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Douglas Millard Baker | | | 2a. DATE OF DEATH MONTH DAY YEAR September 29, 1987 | | 2b. HOUR 8 a.m. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 02/27/09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH Reisterstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 411 Chartley Park Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Scaleman | 12b. KIND OF BUSINESS OR INDUSTRY Steel | |
| 13a. STATE MD | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Reisterstown | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 411 Chartley Park Rd. 21136 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry C. Baker | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Willians | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | 17. INFORMANT 411 Chartley Park Rd. Mrs. Madeline E. Baker Reisterstown MD 21136 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEAD AND NECK CANCER</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 19 <u>87</u> , to <u>PRESNT</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>SEPT 1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>GARY I. COHEN</u> | | DEGREE <u>MD</u> ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED <u>9/30/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GARY I. COHEN</u> | | 22e. ADDRESS <u>711 W. YORK ST. BALTO. MD 21211</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) <u>Burial</u> | | 23b. DATE <u>10/02/87</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Garrison Forrest Vet</u> | | 23d. LOCATION <u>Owings Mills, Baltimore, Md</u> |
| 24. FUNERAL DIRECTOR OR <u>ECKHARDT</u> | | FUNERAL CHAPEL, OWINGS, MILLS, MD 21117 | | 25a. DATE REC'D BY REGISTRAR <u>SEP 30 1987</u> | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pendley</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

007302 OCT-1-01

20% COTTON FIBER

EXTRA DOWN

SEP 30 1901

066130 SEP 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25416

| | | | | | | | | | | | | | | | |
|---|--|---------|-------------------|---|--|---|--|--|----------------|------------------|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF ESTI. DEATH MATED | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| GEORGE | | | BALLARD, Jr | | | <input checked="" type="checkbox"/> 9 10 1987 | | | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | | Black | | June 15, 1900 | | 87 YRS. | | MONTHS DAYS | | HOURS MIN | | 9 10 1987 | | 2:43 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| N.C. | | | | U.S.A. | | | | | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | 1904 Burnwood Rd. | | | | Truck Helper | | | | Factory | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. STREET ADDRESS | | | |
| Md. | | | | | | | | Baltimore | | | | 1904 Burnwood Rd. 21239 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | |
| George | | | | Nancy | | | | NO | | | | 241-263689A | | | |
| 17. INFORMANT | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | 19. ADDRESS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Perkins | | | | Arteriosclerotic cardiovascular disease | | | | 1904 Burnwood Rd. | | | | | | | |
| | | | | PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| | | | | IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 20. AUTOPSY? | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| 22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| Dennis F. Smyth, M.D. | | | | Assistant, MEDICAL EXAMINER | | | | 9-12-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Removal | | | | 9-14-87 | | | | Skipper Hill Cemetery | | | | Leland N.C. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Randolph J. Collick | | | | 4316 E. Oliver St. | | | | SEP 17 1987 | | | | Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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BP

DHMH - 17
(VR A15 ME (1))

000130 SEP 18 01



066789 SEP 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25417

| | | | | | | | |
|---|--|---|--|---|--------------------------------------|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>ETTA</u> MIDDLE <u>L.</u> LAST <u>BALL</u> | | | 2a. DATE OF DEATH MONTH <u>9</u> DAY <u>21</u> YEAR <u>87</u> | | 2b. HOUR <u>12³⁰</u> M | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>Cauc</u> | | 5. DATE OF BIRTH MONTH <u>2</u> DAY <u>27</u> YEAR <u>1898</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>89</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Delaware</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balto City</u> MD | |
| 10. CITY OR TOWN OF DEATH <u>Balto</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Keswick</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Maryland</u> COUNTY <u>Baltimore</u> | | 13b. CITY OR TOWN <u>Towson</u> | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE <u>23 Bellows Ct. 21204</u> | |
| 14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>Dickerson</u> LAST <u>Dickerson</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Jane</u> MIDDLE <u>Meyers</u> LAST <u>Meyers</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. <u>219-84-1906</u> | | 17. INFORMANT <u>Gloria B. Beckwith - same as #13c</u> | | | ADDRESS |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>42 hrs</u> <u>5 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-20</u> 19 <u>87</u> , to <u>9-21</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9-20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>E. Hunter Wilson, Jr.</u> | | | | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9-21-87</u> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. Hunter Wilson, Jr.</u> | | | | 22d. ADDRESS <u>101 W. Read St., Balto., Md. 21201</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>9-22-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Timonium, Balto., Md.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Ruck Towson Funeral Home, Inc., Towson, Md. 21204</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 24 1987</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julia T. ...</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been voided by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. The funeral director should remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a death.

BP

066782 SEP 22 61

SEP 24 1961

066494 SEP 23 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25118

| | | | | | |
|--|---|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT G BALLARD | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 17, 1987 | | 2b. HOUR P 6:20 |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR November 27 1966 | | 6. AGE (IN YEARS LAST BIRTHDAY) 20 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Pep Boys |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 317 N. Hammonds Ferry Road 21061 |
| 14. FATHER'S NAME FIRST MIDDLE LAST James L. Ballard | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva M. Pease | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-82-4510 | | 17. INFORMANT ADDRESS Eva M. Ballard Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>24 hrs</u> <u>1 week</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Antibody positive for Human Immunodeficiency Virus</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> / 19 <u>87</u> to <u>9/17</u> / 19 <u>87</u> , that (I) <u>(we)</u> lost <u>saw</u> the deceased alive on <u>9/17</u> / 19 <u>87</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | |
| 22b. SIGNATURE <u>Patrick Hwu</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick Hwu | | 22e. ADDRESS 600 N. W. St. #2105 The Johns Hopkins Hospital, Baltimore, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/19/87 | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Park | | 23d. LOCATION Baltimore Howard MD | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | | 25. DATE REC'D. BY REGISTRAR SEP 22 1987 | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit form. The funeral home must retain pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. It is the funeral home's responsibility to ensure the proper filing of the certificate.

IMPORTANT: If item 21 is marked on item 18, show any injury, trauma, or other traumatic event, the medical examiner must be notified at once.

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SEP 28 1971

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25419

| | | | | | | | |
|--|--|---|---|---|-------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) AMY Lynn BANKARD | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 3, 1987 | | 2b. HOUR 2:27^P | | |
| 3 SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 15, 1987 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 19 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependant | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Essex | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 299 Montrose Ave. 21221 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William G. Bankard, Jr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JoAnne Balakier | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | | 17. INFORMANT ADDRESS Mr. & Mrs. William Bankard Same as 13e. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Vasospasm DUE TO, OR AS A CONSEQUENCE OF (c) Complex Congenital Heart Disease | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR 12 Hrs 2 wks. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Asplenia | | | | | | | |
| 19a. DATE OF OPERATION 9-2-87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Complex Congenital Heart Disease | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-16-87 to 9-3 , that (I) (we) last saw the deceased alive on 9-3 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE PROV. MD. | | | | DEGREE MD. | | 22c. DATE SIGNED 9-3-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DEVALERIA | | | | 22e. ADDRESS J.H.H. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-5-87 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1987 | | 25b. REGISTRAR'S SIGNATURE Edison P. ... | |

MEDICAL CERTIFICATION

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(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. This permit is valid for 14 days after the date of death. It is not valid for removal with the State Dept. of Health and Mental Hygiene prior to 10 days after the date of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

084228 222420

065277 SEP 14 87

FOR
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 2-5420

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES F. BANKS | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-5-87 | | 2b. HOUR 4P M |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 12 11 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Jesus Boergers, Central | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY N/A |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN BALTO | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 511 E. 20th STREET 21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Banks | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melvina Keene | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes | | 16b. SOCIAL SECURITY NO. 217-05-9828A | | 17. INFORMANT ADDRESS James Keene 1608 Mt Royal Ave. Apt. 1210 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (c) Renal failure | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CVA Recurrent UTI + Volume Depletion CHF fluid | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/4 , 19 87 , to 9/4 , 19 87 , that (I) (we) lost saw the deceased alive on 9/4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Eleanor Y. Hixon, MD | | | | 22c. DATE SIGNED 9/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eleanor Y Hixon, MD | | | | 22e. ADDRESS 924 W. North Ave | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VA CEM. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS, MD | | 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 09 1987 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completely page 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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MADE IN U.S.A.



SEP 09 1901

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25421

REG. NO.

FOR
1 - STATE
REGISTRAR

066242 SEP 18 87

| | | | | | | |
|--|---|---|---|--|---|---|
| DECEASED NAME (TYPE OR PRINT) FIRST: Marie A. LAST: Baptist | | | 2a. DATE OF DEATH MONTH: 9 DAY: 15 YEAR: 87 | | 2b. HOUR 6:25 AM | |
| 3. SEX F | 4. RACE B 2 | 5. DATE OF BIRTH MONTH: 3 DAY: 27 YEAR: 02 | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME CITY, GIVE STREET ADDRESS) Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST: James MIDDLE: LAST: Jennings | | | 15. MOTHER'S MAIDEN NAME FIRST: Anna MIDDLE: LAST: Jennings | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-16-0857 | | 17. INFORMANT ADDRESS Wm. H. Baptist, Jr 517 Normandy Ave | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) this hospital attended the deceased from 9/14 19 87 to 9/15 19 87, that (I) (we) last saw the deceased alive on 9/15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.) | | | | | | |
| 22b. SIGNATURE Sartarazi MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/15/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sartarazi, MD | | 22e. ADDRESS Sinai Hospital of Baltimore | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY St Stephens Church Cem | | 23d. LOCATION CITY OR TOWN: Unionville COUNTY: STATE: Md |
| 24. FUNERAL DIRECTOR NAME: Wm. C. March F/H West 4300 Wabash Avenue ADDRESS: | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 18 1987 Julia Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Baltimore City

Baltimore City

455 N. Hillen St. 21201

Baltimore City

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66262 SEP 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25422

| | | | | | | | | |
|--|---|--|--------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST RICHARD E. BARBOUR | | | MONTH DAY YEAR SEPTEMBER 13, 1987 | | | 10:35 A | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS |
| MALE | BLACK | MONTH DAY YEAR 7 17 56 | | 31 YRS | | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MD | U.S.A. | | | BALTIMORE CITY MD | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | | N/A | | N/A | | |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | | |
| MD | | | | BALTO. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST JOSEPH BARBOUR | | | FIRST MIDDLE LAST EVELYN JUSTICE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | 214-68-8686 | | EVELYN BARBOUR 1557 STONEWOOD ROAD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 MIN.</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>GI HEMORRHAGE</u> | | | | | | | | <u>5 DAYS</u> |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>CIRRHOSIS</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ECH ABUSE</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>87</u> , to <u>9/13</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>9/13</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Scott Carnivale MD</u> | | DEGREE | | 22c. DATE SIGNED <u>9/13/87</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SCOTT CARNIVALE</u> | | 22e. ADDRESS <u>600 N. Wolfe St. Balto, Md.</u> <u>THE JOHNS HOPKINS HOSPITAL 21205</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | 9/18/87 | | MOUNT ZION CEMETERY | | LANSDOWNE MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | SEP 17 1987 | | <u>Maria Davidson-Randall</u> | | |

MEDICAL CERTIFICATION

22a. I certify that (I) (this hospital) attended the deceased from 9/13, 1987, to 9/13, 1987 that (I) (we) last saw the deceased alive on 9/13, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Scott Carnivale MD DEGREE
22c. DATE SIGNED 9/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCOTT CARNIVALE
22e. ADDRESS 600 N. Wolfe St. Balto, Md.
THE JOHNS HOPKINS HOSPITAL 21205

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
23b. DATE 9/18/87
23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY
23d. LOCATION CITY OR TOWN COUNTY STATE LANSDOWNE MD

24. FUNERAL DIRECTOR NAME ADDRESS
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE
25a. DATE REC'D. BY REGISTRAR SEP 17 1987
25b. REGISTRAR'S SIGNATURE Maria Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Medical examiner must be notified if an important: If item 21 is marked or item 18 shows any injury.

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U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NICHOLAS M. BARILLA M NICHOLAS BARILLA | | 2a. DATE OF DEATH MONTH DAY YEAR 9/1/87 | | 2b. HOUR 1324 M | |
| 3. SEX MALE | | 4. RACE CAUCASIAN WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3/10/1910 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 77 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA | | 8. CITIZEN OF WHAT COUNTRY? USA | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rigger | | 12b. KIND OF BUSINESS OR INDUSTRY Ship Yard | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | |
| 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Angelo Barilla | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette Scallion | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16b. SOCIAL SECURITY NO. 171-01-4626 | | 17. INFORMANT Mary A. Barilla | | 17. ADDRESS Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated INTRAVASCULAR COAGULATION DUE TO, OR AS A CONSEQUENCE OF (b) INTERSTITIAL PNEUMONITIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 2 days 7 days | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 7 days | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (he) (this hospital) attended the deceased from August 23, 1987 to Sept 1, 1987 that (we) (we) last saw the deceased alive on Sept 1, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Bert F. Morton | | DEGREE M.D. | | 22c. DATE SIGNED Sept. 2, 1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bert F. Morton M.D. | | 22e. ADDRESS St. Agnes Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 09/04/87 | | 23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Gardens | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville, Ho., MD | | 24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home, Catonsville, MD | | | |
| 25a. DATE RECEIVED BY REGISTRAR SEP 4 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Dendron-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (page 3) and 2 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 and 513 and 514 and 515 and 516 and 517 and 518 and 519 and 520 and 521 and 522 and 523 and 524 and 525 and 526 and 527 and 528 and 529 and 530 and 531 and 532 and 533 and 534 and 535 and 536 and 537 and 538 and 539 and 540 and 541 and 542 and 543 and 544 and 545 and 546 and 547 and 548 and 549 and 550 and 551 and 552 and 553 and 554 and 555 and 556 and 557 and 558 and 559 and 560 and 561 and 562 and 563 and 564 and 565 and 566 and 567 and 568 and 569 and 570 and 571 and 572 and 573 and 574 and 575 and 576 and 577 and 578 and 579 and 580 and 581 and 582 and 583 and 584 and 585 and 586 and 587 and 588 and 589 and 590 and 591 and 592 and 593 and 594 and 595 and 596 and 597 and 598 and 599 and 600 and 601 and 602 and 603 and 604 and 605 and 606 and 607 and 608 and 609 and 610 and 611 and 612 and 613 and 614 and 615 and 616 and 617 and 618 and 619 and 620 and 621 and 622 and 623 and 624 and 625 and 626 and 627 and 628 and 629 and 630 and 631 and 632 and 633 and 634 and 635 and 636 and 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Item #8, G-632,

FOR Afvd. Fr. Parents,

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

25425

REGISTRAR Gbj.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b HOUR | | |
| TIMOTHY BARNES | | | | | | 2a DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b HOUR | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS) | | | 7a DATE KNOWN OF DEATH | | |
| MALE | | | BLACK | | | 12 22 1968 | | | 18 YRS. | | | 9-27-87 | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED | | | NEVER MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| NEW YORK, N.Y. | | | U. S. A. | | | WIDOWED | | | DIVORCED | | | Baltimore City | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | Sinai Hospital | | | STOCK CLERK | | | AMES. CO. | | | | | |
| 13a STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? | | | 13e STREET ADDRESS | | |
| MARYLAND | | | BALTO | | | BALTIMORE | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | MARYLAND 21207 6802 BROMPTON ROAD, BALTIMORE, | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b SOCIAL SECURITY NO. | | | 17 INFORMANT | | |
| ALFONSO | | | EMMA | | | NO | | | 219-96-4198 | | | MR. & MRS. ALFONSO BARNES | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20 AUTOPSY? | | | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head injuries with complications</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</u> (c) <u></u> | | | 20 AUTOPSY? | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS | | | 21b TIME OF INJURY | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | 22a I certify that I took charge of the remains described above, held an | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 1:37a P.M. 9-13-87 | | | driver of an auto/fixed object impact | | | death resulted from | | | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | |
| 21d INJURY OCCURRED | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f LOCATION | | | 22b I certify that I took charge of the remains described above, held an | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | street | | | Morris Rd. & Hilton Pkwy. Baltimore, Md. STATE | | | 22b I certify that I took charge of the remains described above, held an | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (CITY OR TOWN) | | | COUNTY STATE | | |
| BURIAL | | | 10/03/1987 | | | WOODLAWN CEMETERY | | | BALTIMORE, MARY | | | | | |
| 24 FUNERAL HOME (NAME) | | | 25a DATE REC'D. BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | | 26a I certify that I took charge of the remains described above, held an | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | |
| 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | | | OCT 07 1987 | | | | | | 26a I certify that I took charge of the remains described above, held an | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN TO THE FUNERAL HOME WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25a

BP

DHMH - 17
(VR A15 ME (5))

0/29/87, by Not. State of

001-001 120700



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
- REGISTRAR

067285

| | | | | | |
|---|---|---|---|--|--|
| 1. NAME FIRST MIDDLE LAST CHARLES C. BARONE | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 24 87 | | 2b. HOUR 7:30 PM |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 7 7 32 | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. of Maryland | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist | | 12b. KIND OF BUSINESS OR INDUSTRY |

| | | | | | |
|--|---|--|---|---|--|
| 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 6 Upland Road Apt. A3 21210 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Frank Barone | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Jerris | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea | 16c. SOCIAL SECURITY NO. 063-28-3638 | 17. INFORMANT ADDRESS Mrs. Marlene C. Barone 6 Upland Rd. 21210 | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MALIGNANT Fibrous Histocytoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 3 , 19 87 , to Sept 24 , 19 87 , that (I) (we) last saw the deceased alive on Sept 24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE R. Ugen | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 9/24/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD S. KAPLAN MD | | 22e. ADDRESS 22 S. GREENE ST. BALTIMORE, MD 21201 | |

| | | | |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/28/87 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. |
| 24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC. | | ADDRESS 6500 York Rd. | 25a. DATE REG'D BY REGISTRAR SEP 30 1987 |
| | | 25b. REGISTRAR'S SIGNATURE Richard S. Kaplan | |

001-100 202500

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

FOR
1- STATE
REGISTRAR

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|--|--|--|---|--|--|--|--|--|--|--|--|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) LAWRENCE | | | MIDDLE BARRETT | | | LAST BARRETT | | | 2a DATE OF DEATH MONTH DAY YEAR Sept 3 87 | | | 2b HOUR 1130AM | | |
| 3 SEX Male | | | 4 RACE White | | | 5 DATE OF BIRTH MONTH DAY YEAR 8-29-1900 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 87 | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE | | | MD. | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE CITY | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gardener | | | 12b KIND OF BUSINESS OR INDUSTRY Landscaping | | | | | |
| 13a STATE Maryland | | | 13b COUNTY Baltimore | | | 13c CITY OR TOWN Baltimore | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS / ZIP CODE 1453 Medfield Avenue 21211 | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Thomas Barrett | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Flor | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO - | | | 16b SOCIAL SECURITY NO. 212-05-2008 | | | 17 INFORMANT ADDRESS Hazel Klacik 1453 Medfield Avenue 21211 | | |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) hypoxia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) acute renal failure 3 days | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

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|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: prostate carcinoma | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | |
| 22a I certify that (I) (this hospital) attended the deceased from Sept 1 , 19 87 , to Sept 3 , 19 87 , that (I) (we) last saw the deceased alive on Sept 3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE D. Steve Hal | | DEGREE Attending Physician | |
| 22c DATE SIGNED Sept 3, 87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steve Hench | |
| 22e ADDRESS UNION MEMORIAL HOSPITAL | | | |

| | | | | | | | |
|--|--|------------------------------|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-5-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Memorial | | 23d LOCATION CITY OR TOWN COUNTY STATE Sykesville, How. Co. Md. | |
| 24 FUNERAL DIRECTOR NAME ADDRESS Burgee-Henss Funeral Home 3631 Falls Rd. 21211 | | | | 25a DATE REC'D. BY REGISTRAR SEP 9 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Rudnick | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1. This copy should be filed with you 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25428

1. FOR
STATE
REGISTRAR

065154 SEP 10 87

| | | | | | |
|---|---|---|--|--|---|
| DECEASED NAME (Type in full) EDWARD ANDERSON BARTEE | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/8/87 | | 2b. HOUR M |
| 3 SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 12 8 1913 | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1630 Division St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter | 12b. KIND OF BUSINESS OR INDUSTRY Steel | |
| 13a. STATE Md. | | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wally H. Bartee | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary R. Brown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | 17. INFORMANT ADDRESS Mrs. Emma Bartee 1630 Division St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelium was not at time of death but pat. had end stage COPD on chronic O₂ steroids DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DM DUE TO, OR AS A CONSEQUENCE OF (c) SUT | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8+ weeks | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 66 S. Green Street | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4- 9- 19 87 , to 8 19 87 , that (I) (we) last saw the deceased alive on 8- 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE V. Mossman MD | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 9-9-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. MOSSMAN MD | | 22e. ADDRESS WMMS 66 S. Green Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/12/87 | 23c. NAME OF CEMETERY OR CREMATORY Cornerstone Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland VA. | | |
| 24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons | | ADDRESS 1701 Laurens St. | 25a. DATE REC'D. BY REGISTRAR SEP 9 1987 | 25b. REGISTRAR'S SIGNATURE John Benson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be detached for use as the burial-transit permit. Then please remove carbon-copy paper and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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065908 SEP 17 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25429

| | | | | | | |
|---|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FURMAN BARTON | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-13-87 | | 2b. HOUR 8:45 AM | |
| 3. SEX m | 4. RACE B 2 | 5. DATE OF BIRTH MONTH DAY YEAR 3-17-18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John I. DENTON MEDICAL CENTER Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. 219-07-3594 | | 17. INFORMANT ADDRESS Loretta Brown 2019 N. Payson St | |

MEDICAL CERTIFICATION

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolyte Abnormalities DUE TO, OR AS A CONSEQUENCE OF (b) prostate carcinoma with bone metastases DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48^h 1 year |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Cancer of the larynx

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION _____ | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) _____ | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____ | 21f. LOCATION CITY OR TOWN COUNTY STATE _____ | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 8 19 87 , to Sept 13 19 87 , that (I) (we) lost saw the deceased alive on Sept 13 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Linda Parkhurst | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 9/13/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LINDA PARKHURST | | 22e. ADDRESS UNIV. OF MD HOSP. 120 S. GREENE ST, BALTIMORE | |

| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/17/87 | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD |
| 24. FUNERAL DIRECTOR MARCH F/H 4300 WADSWORTH AVE | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1987 | 25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certification. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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20% COTTON FIBER

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25430

| | | | | | |
|--|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Edward</u> MIDDLE <u>W.</u> LAST <u>Base</u> | | 2a. DATE OF DEATH MONTH <u>9</u> DAY <u>24</u> YEAR <u>87</u> | | 2b. HOUR <u>9¹⁰</u> M | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>03</u> DAY <u>10</u> YEAR <u>60</u> | |
| 6. AGE (IN YEARS LAST BIRTHDAY) <u>87</u> YRS | | IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> | | IF UNDER 24 HRS HOURS <u> </u> MIN. <u> </u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO CITY</u> MD. | | 10. CITY OR TOWN OF DEATH <u>BALTO</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Mercy Hospital</u> | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>SUPERVISOR</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>WESTERN UNION</u> | | 13a. STATE <u>MD</u> | |
| 13b. COUNTY <u> </u> | | 13c. CITY OR TOWN <u>BALTO</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS <u>524 N Charles St</u> | | 14. FATHER'S NAME FIRST <u>Frank J.</u> MIDDLE <u>Base</u> LAST <u> </u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Rose</u> MIDDLE <u>Strejcek</u> LAST <u> </u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> | | 16b. SOCIAL SECURITY NO. <u>215-09-7766</u> | | 17. INFORMANT ADDRESS <u>21204</u> <u>Marie Peddicord 1672 Thetford Road</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u> </u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>9/24</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL <u>Burial</u> | | 23b. DATE <u>9-28-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u> | |
| 23d. LOCATION <u>Balto., Md.</u> | | 23e. STATE <u>MD</u> | | 23f. CITY OR TOWN | |
| 24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane, Balto., Md. 21213</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 25 1987</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | 25c. ADDRESS | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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00003 29 30 01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) James James | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 27 87 | | | 2b. HOUR 5:30 P.M. | | | | | |
| 3 SEX Male | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 1 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bons Secours Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Disability | | | |
| 13a. STATE Md | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1429 Edmondson Ave 21223 | | |
| 14 FATHER'S NAME FIRST MURPHY MIDDLE LAST BUSHVILLE | | | 15 MOTHER'S MAIDEN NAME FIRST NELLIE MIDDLE LAST MCLENDON | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 217-22-4229 | | 17 INFORMANT Mrs. Elizabeth Bradley | | | | | ADDRESS 4015 Chatham Rd 21215 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Adeno-Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sepsis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 9/20, 19 87, to 9/27, 19 87, that (1) (we) lost saw the deceased alive on 9/27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert J. Moss | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/27/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Moss | | | | | 22e. ADDRESS Bons Secours Hosp. 1, Baltimore | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial | | | 23b. DATE 10-1-87 | | 23c. NAME OF CEMETERY OR CREMATORY Aebutus Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. Md | | | | |
| 24 FUNERAL DIRECTOR NAME Joseph L. Russ | | | | | ADDRESS 2222 W. North Ave | | 25a. DATE REC'D BY REGISTRAR 9-30-87 | | 25b. REGISTRAR'S SIGNATURE | | |

BP

104-100-505500

067305 OCT-1987

FOR
STATISTICAL
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---------|---|------------------|--|---|--|----------------|---|------------------|--|--|---|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| DANA K. BAUER | | | | | | 9-27-87 | | | 19 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| Male | | White | | July 25, 1960 | | 27 YRS. | | MONTHS DAYS | | HOURS MIN. | | 9-27-87 | | 10:31 P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | NEVER MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | | | USA | | | WIDOWED | | | DIVORCED | | | Baltimore City MD. | | | |
| 11. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Baltimore | | | University Hospital STU | | | Truck Driver | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | |
| Md. | | | Harford | | | Edgewood | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 2423 Hansen Rd. 21040 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| Edward R. Bauer Jr. | | | Nancy A. Noll | | | no | | | 214-76-7603 | | | Mrs. Nancy A. Bauer 5727 Newholme Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> | | | | | | | | | | | | | | | |
| (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | | | | | | | | | | | |
| (c) <u></u> | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| | | | 8:50 P 9-27-87 | | | self/inflicted | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | | |
| | | | bedroom | | | 2423 Hanson Rd. Edgewood Maryland | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | | | | | |
| <i>Margarita A. Korell</i> | | | Assistant | | | 9-28-87 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | 111 Penn Street | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | | |
| Burial | | | Sept. 30, 1987 | | | Gdns. of Faith | | | Baltimore Maryland | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Leonard J. Ruck Inc. Baltimore, Maryland | | | SEP 30 1987 | | | <i>Julia Davidson-Randall</i> | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FACED 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE A SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 1. PAGE 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

067302 OCT-197

July 27, 1961

Frank Driver

102 Hansen St. WINDY

Kelly

Shore

Harbor St.

Harbor

102 Hansen St. WINDY

102 Hansen St.

no



Harbor

102 Hansen St.

102 Hansen St.

Harbor

102 Hansen St. WINDY

065828

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| FOR STATE REGISTRAR 1- DATE OF DEATH SEP 16 1987 | | FIRST JOHN | | MIDDLE C. | | LAST BEALEFELD | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 13 1987 | | 2b. HOUR M 2:20 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12-11-1946 | | 6. AGE (IN YEARS) LAST BIRTHDAY 40 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator Gen.-Lowry | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1101 Washington Blvd. 21230 | | | |
| 14. FATHER'S NAME John | | 15. MOTHER'S MAIDEN NAME Edna L. Dreyer | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT John C. Bealefeld Jr. 38 Stone Dr. 21122 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Condition, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOURS MIN. MONTH DAY YEAR 11:45 9-12-1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver of auto/fixed object impact. | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Ostend & Sharp Sts., Balto. City MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Poison <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER DATE SIGNED 9-13-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-16-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Linden Park Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME John J. Carr, Jr. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE John J. Carr, Jr. | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. RETURN WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

062938 SEP 12 81



065137 SEP 16 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST DORIS | MIDDLE BEARMAN | LAST BEARMAN | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 4, 1987 | 2b. HOUR 8:02 | P M |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR MAY 11, 1918 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REAL ESTATE AGENT | 12b. KIND OF BUSINESS OR INDUSTRY FIOLA BLUM CO. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 7 SLADE AVE., APT. 103 #21208 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GOODARD CHIRCUS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE RAPHAEL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT DR. SHELDON B. BEARMAN 23 WALLEY CT. LUTHERVILLE, MD 21093 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 DAYS</u> <u>9 DAYS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | |
| 19a. DATE OF OPERATION <u>8/27/87</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CORONARY OCCLUSION</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/27/87</u> , 19 <u>87</u> , to <u>9/14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>David L. Johnson</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>9/14/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID L. JOHNSON</u> | | | | 22e. ADDRESS <u>JOHNS HOPKINS DEPT. OF SURGERY</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-6-87 | | 23c. NAME OF CEMETERY OR CREMATORY BETH JACOB CONG. | | 23d. LOCATION CITY OR TOWN COUNTY STATE FINKSBURG CARROLL MD | |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., INC.</u> 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | 25a. <u>SEP 09 1987</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

062137 SEP 10 87

1 28 of 100
21003 11/11/87

SEP 09 1987

067677 OCT 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) ANNA Lucille Beasley | | 2a DATE OF DEATH MONTH DAY YEAR 9 27 87 | | 2b HOUR 9 15 PM | |
| 3 SEX F | 4 RACE BLK 2 | 5 DATE OF BIRTH MONTH DAY YEAR 3 10 22 | | 6 AGE (IN YEARS LAST BIRTHDAY) 65 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Inns of Evergreen Central | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) stock clerk | | 12b KIND OF BUSINESS OR INDUSTRY retail toys |
| 13a STATE MD | | 13b COUNTY Balt. City | 13c CITY OR TOWN Balt. | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Mark Hubbard | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Luna Ford | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown | | 16b SOCIAL SECURITY NO. 2 58-3664 | | 17 INFORMANT ADDRESS Barbara Eaton EN Inns of Evergreen Central | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a TIA; DIABETES MELLITUS; DEMENTIA. | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from July 19 83 to 7/27 / 19 87 that (I) (we) lost saw the deceased alive on 9/13 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE Yonni FAKUNLE | | DEGREE MD | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Yonni FAKUNLE | | 22e ADDRESS 2300 GARRISON BLVD BALD 21216 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 10-1-87 | | 23c NAME OF CEMETERY OR CREMATORY Garrison Forest | |
| 24 FUNERAL DIRECTOR NAME Brown-Thompson F.H. | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 25a DATE REC'D. BY REGISTRAR OCT 2 1987 | |
| | | 25b REGISTRAR'S SIGNATURE Julia Davidson-Pendley | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Their plates remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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F LK 3 10 02
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066507 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

OTTILIE I. BECK

| | | | | | | | |
|---|--|--|---|---|---------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OTTILIE I. BECK | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/21/87 9 21 87 | | 2b. HOUR 623 AM | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 16 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER | | 12b. KIND OF BUSINESS OR INDUSTRY BAKERY | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY HOWARD | | 13c. CITY OR TOWN ELLICOTT CITY | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HERMAN F. LUCKE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FREDERICKA APPLE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-42-8054 | | 17. INFORMANT ADDRESS PHOENIX 21131 JUNE RHOADS 14116 JARRETTVILLE PIKE MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sepsis DUE TO, OR AS A CONSEQUENCE OF (b) urinary tract infection DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/18 19 87 , to 9/21 19 87 , that (I) (we) lost saw the deceased alive on 9/21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE K. Rikabi | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. K. RIKABI | | | | 22e. ADDRESS 900 CATON Avenue Saint Agnes | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 09/23/87 | | 23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME LEROEY M & RUSSELL C WITZKE FUNERAL HOME | | | | 25. DATE REC'D. BY REGISTRAR SEP 22 1987 | | | |
| 26. ADDRESS 1630 EDMONDSON AVE. CATONSVILLE MD 21228 | | | | 27. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

008201 SEP 33 61

SEP 33 1961

067390 OCT 1 1987 87 25437

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|---|---|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Caroline Alice Bell | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 - 26-87 | | 2b. HOUR 145 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 01/12/17 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 70 yrs. | | 7. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Hospital | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland | | 12b. COUNTY Baltimore | | 12c. CITY OR TOWN Baltimore | | |
| 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS 100 S. Eaton St./21224 | | 13c. ZIP CODE 21224 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Weinbeck | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Buettner | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | |
| 16b. SOCIAL SECURITY NO. 217-52-7436-A | | 17. INFORMANT John Bell | | 17. ADDRESS 100 S. Eaton St. Balto. 21224 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <i>Richard Bennett</i> | | 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED 9-28-87 | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bennett M.D. | | 22f. ADDRESS 5200 Eastern Ave Balto 21224 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 09/29/87 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | |
| 23d. LOCATION CITY OR TOWN Baltimore, Maryland | | 23e. DATE REC'D. BY REGISTRAR SEP 30 1987 | | 23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeiler, Inc. 700 S. Conkling St. 21224 | | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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OFFICIAL MAIL

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2, and fill in the space after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) | | 3. FIRST MIDDLE LAST | | 4. DATE OF DEATH MONTH DAY YEAR | | 5. HOUR MIN. | |
| 587 | | ALBERT | | BENBOW (BINBOW) | | SEPTEMBER 30, 1987 | | 12:55 a | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| male | | black | | 5 25 1950 | | 37 | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md | | U S A | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Maryland General Hospital | | Unemployed | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Md | | | | Baltimore | | | | 21201 221 N. Fremont Avenue Apt 1307 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Albert | | Benbow, Sr | | Geraldine Burger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 217-52-5574 | | Geraldine Garriss 126 N. Fremont Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Upper Gastrointestinal hemorrhage with esophageal varices. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Marked hepatic micro nodular cirrhosis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cardiomegaly | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from September 29, 19 87, to September 30, 19 87, that (X) (we) last saw the deceased alive on September 30, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| | | | | | | | | 9/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| M. S. S. S. S. S. | | c/o Maryland General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 10/5/87 | | Cedar Hill Cemetery | | Anne Arundel Co Md | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H West | | 4300 Wabash Avenue | | OCT 02 1987 | | Julia Sanders-Randall | | | |

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067208 OCT-2-85

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CATHERINE G. BENINATI | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-20-1987 | | 2b. HOUR M | |
| 3. SEX FEMALE CATHERINE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5-30-1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | | 12b. KIND OF BUSINESS OR INDUSTRY Tower Dept. Store | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. | | 13c. CITY OR TOWN Cockeysville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 6 B Lakeridge Place 21030 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Steve | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Mortellaro | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| 16b. SOCIAL SECURITY NO. 220-12-7648 | | 17. INFORMANT Michael J. Beninati ADDRESS 6B Lakeridge Place Cockeysville, MD 21030 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>REUMATOID ARTHRITIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>17</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>John C. Miller</i> | | | | DEGREE MD | | 22c. DATE SIGNED 9/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-24-87 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, MD. | |
| 24. FUNERAL DIRECTOR NAME John C. Miller, Inc.-6415 Belair Road-21206 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i> | |

MEDICAL CERTIFICATION

9/24/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

065929 SEP 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon parts 1, 2, 3, and 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it should be examined and be certified as such.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST Louie E. Bennett | | | | MONTH DAY YEAR 09/11/87 | | | | 545 P.M. | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | Black | | MONTH DAY YEAR 07/17/07 | | 80 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| CA. | | USA | | | | BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Loch Raven Veteran's Hosp. | | | | Retired | | N/A | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MD | | | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1133 ORLEANS STREET 21202 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Unknown | | | | Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes ARMY | | | | 212-05-9570 | | DORIS BENNETT 1133 ORLEANS STREET | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Pneumonia | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF, (b) Cerebrovascular Accident. | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF, (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Squamous Cell Carcinoma of Left Lung | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | STREET | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/30 19 87 to 9/11 19 87 that (I) (we) last saw the deceased alive on 9/11 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| Steven Dellon | | | | MD | | | | | | 9/11/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Steven Dellon MD. | | | | 27. S. Greene Street Baltimore, MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | | | 9/17/87 | | GARRISON FOREST CEM. | | OWINGS MILLS COUNTY MD | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE | | | | SEP 16 1987 | | | | Julia Johnson-Rublee | | | |

0022030 SEP 17 81

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25441

| | | | | | | | |
|--|--|--|--|--|------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Marian</u> MIDDLE: <u>J.</u> LAST: <u>Bennett</u> | | | 2a. DATE OF DEATH MONTH: <u>9</u> DAY: <u>7</u> YEAR: <u>87</u> | | 2b. HOUR <u>1230 P.M.</u> | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH: <u>10</u> DAY: <u>17</u> YEAR: <u>18</u> | | 6. AGE (IN YEARS) (AST BIRTHDAY) <u>76</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Frances Scott Key Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE <u>128 Kingship Road 21222</u> | | 14. FATHER'S NAME FIRST: <u>—</u> MIDDLE: <u>Cumbarland</u> LAST: <u>—</u> | | 15. MOTHER'S MAIDEN NAME FIRST: <u>Mary</u> MIDDLE: <u>—</u> LAST: <u>—</u> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>no</u> | |
| 16b. SOCIAL SECURITY NO. <u>212325271</u> | | 17. INFORMANT ADDRESS <u>George P. Bennett 2000 O'Reilly Ave.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <u>9/2/87</u> 19 <u>87</u> , to <u>9/7/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (2a) (did) (did not) view the body after death. | |
| 22b. SIGNATURE <u>Joseph T. ...</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph T. ...</u> | | 22e. ADDRESS <u>FSK Medical Care</u> | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | |
| 23b. DATE <u>9-11-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u> | | 24. FUNERAL DIRECTOR NAME: <u>Philip E. Cook</u> ADDRESS: <u>1211 Choseco Ave.</u> | |
| 25a. DATE REC'D. BY REGISTRAR <u>SEP 14 1987</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page must be removed from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, certification, or removal.

IMPORTANT: If item 21 is marked or item 18 is left blank, or other traumatic event, the medical examiner may be notified.

062212 SEP 12 83

10% COTTON FIBRE



SEP 14 1987

066919 SEP 28 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and deliver them to the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
- CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY ANGELA BENNETT | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 23 87 | | 2b. HOUR 5:50 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR November 6 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home Maker |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Riviera Bch | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James J. Gannon | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia R. Keaveney | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-20-2494 | | 17. INFORMANT ADDRESS Vincent D. Bennett Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John R. Davis, M.D. | | DEGREE | | 22c. DATE SIGNED 9/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Davis M.D. | | 22e. ADDRESS 101-W Road St - 401 - Baltimore Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore | |
| 23d. LOCATION CITY OR TOWN Baltimore | | 23e. COUNTY Md | | | |
| 24. FUNERAL DIRECTOR George J. Gonce | | 4001 Ritchie Hwy Balto Md | | 25a. DATE REC'D. BY REGISTRAR SEP 25 1987 | |
| 25b. REGISTRAR'S SIGNATURE Julia Anderson-Richard | | | | | |

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ANGELA BENVENUTI

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064790 SEP 14 1987

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25443

REG. NO.

| | | | | | | | | | | | | |
|--|--|---------|--|------------------|---|--|--------------------------|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | |
| WILLIAM E. BENNYHOFF, Sr. | | | | | | 9 1 87 | | | | 5:44 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | |
| Male | | White | | 5-27-1904 | | 83 | | YRS. | | MONTHS DAYS HOURS MIN. | | |
| 9a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Pa. | | | U.S.A. | | | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | | UNION MEMORIAL HOSPITAL | | | | | | Ret. Chauffeur | | Food Chain | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Md. | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 3111 Clearview Ave. 21234 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | | | |
| Franklin A. Bennyhoff | | | Sallie A. Conley | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | |
| No | | | 217-05-4790 | | | I. Alma Bennyhoff, Same as 13e | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> | | | | | | | | | | 12 hrs. | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | 24 hrs. | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) <u>ISCHEMIC BOWEL</u> | | | | | | | | | | 22 hrs. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | | | | | | | |
| NONE | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 8-31-87 | | | Ischemic Bowel | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | |
| | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN COUNTY STATE | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 8-26, 19 87, to 9-1, 19 87, that (1) we last saw the deceased alive on 9-1, 19 87, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| Brent C. Birely | | | | | | MD | | | | 9/1/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | | |
| BRENT C. BIRELY, M.D. | | | | | | UNION MEMORIAL HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | | 9-5-87 | | Govans Presbyterian | | | Balto., Md. | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | | SEP 3 1987 | | Julia Davidson-Randall | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers, page 3 and 4, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

064730 SEP-487

30% COTTON FIBER

WILFAM



065875 SEP 16 1987

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25444

| | | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) George W. Berlin | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 11 87 | | | 2b. HOUR 5:45 PM | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 02 08 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY DISTILLARY | | | | |
| 13a. STATE MD | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN LANSDOWNE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2407 ALMA ROAD 21227 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W. BERLIN, SR. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BRIDGETTE CLARK | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-2126 | | 17. INFORMANT ADDRESS MRS. JOAN RUSHING 1114 ELM ROAD 21227 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/11</u> , 19 <u>87</u> , to <u>9/11</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>9/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 23a. SIGNATURE <u>Louis A. Salas MD (Resident)</u> | | | | | | | | | | 23b. DATE SIGNED 9/11/87 | | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT) Louis A. Salas | | | | | | 23d. ADDRESS 700 South Caton Ave. | | | | | | |
| 23e. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL | | | 23f. DATE 09/15/87 | | 23g. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY | | | 23h. LOCATION Baltimore HOWARD MD | | | | |
| 24. FUNERAL DIRECTOR NAME AMBROSE FUNERAL HOME 1328 SULPHUR SPRING RD. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | | 25b. REGISTRAR'S SIGNATURE <u>Lisa Gordon-Rodgers</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

062872 SEP 1981

Very faint text at the bottom left corner, possibly a date or reference number.

066390 SEP 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|-------------------------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ERNEST L. Lee BERRY | | 2a. DATE OF DEATH MONTH DAY YEAR 9/16/87 | | 2b. HOUR 7:44p M | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Oct 22, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital, Baltimore | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Worker | |
| 12b. KIND OF BUSINESS OR INDUSTRY Const. | | 13a. STREET ADDRESS / ZIP CODE 4641 Manordene Rd., 21229 | | | |
| 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Berry | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Cornelius | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS N.Y. 10550 Mrs. Wanda Binns, 128 E. 4th St. Mt. Vernon | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embryonal Phallomyosarcoma DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/4/87, 19, to 9/16/87, 19, that (I/we) last saw the deceased alive on 9/16/87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did) did not view the body after death. | | | | | |
| 22b. SIGNATURE Joseph Kim | | DEGREE M.D. | | 22c. DATE SIGNED 9/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HYUN JOSEPH Kim | | 22e. ADDRESS Mercy Hospital, Baltimore MD 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/21/87 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Md. | | 24. FUNERAL DIRECTOR'S NAME Lemmon-Mitchell-Wiedefeld, 10 W. Padonia RD | | 25. DATE REC'D. BY REGISTRAR SEP 21 1987 | |
| 26. REGISTRAR'S SIGNATURE James Davidson | | | | | |

MEDICAL CERTIFICATION

70 55 472 0 2 6 3 3 6

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25440

REG. NO.

| | | | | | | | | |
|--|---------|------------------|---|----------------|------------------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| PAULINE BERTLING | | | 9-25-87 | | | M | | |
| 1. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 7d. HOUR | |
| Female | White | Jan 14, 1926 | 61 YRS. | MONTHS | DAYS | 9-25-87 | 12:43P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| Maryland | | | U.S.A. | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Baltimore | | | Lincoln Convalescent Center | | | Baltimore City | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Baltimore | | | Lincoln Convalescent Center | | | Never Worked | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. STREET ADDRESS | | |
| Maryland | | | Owings Mills | | | Rosewood State Hospital | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. ADDRESS | | |
| Augustus Bertling | | | Mary E. Larkin | | | 21234 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| No | | | 220-05-3675 | | | Wilton L. Bertling | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. INFORMANT | | | 20. ADDRESS | | |
| PART I DEATH WAS CAUSED BY: | | | 21. INFORMANT | | | 22. ADDRESS | | |
| 9104 IMMEDIATE CAUSE (a) Drowning complicating mental retardation | | | 21. INFORMANT | | | 22. ADDRESS | | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. | | | 21. INFORMANT | | | 22. ADDRESS | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | 21. INFORMANT | | | 22. ADDRESS | | |
| (b) | | | 21. INFORMANT | | | 22. ADDRESS | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | 21. INFORMANT | | | 22. ADDRESS | | |
| (c) | | | 21. INFORMANT | | | 22. ADDRESS | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| | | | 12:43PM 9-15-87 | | | subject left unattended while being bathed in bathtub | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | |
| | | | 3rd floor shower rm. | | | 1217 W. Fayette Street Baltimore, Md. | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
| Ann M. Dixon, M.D. | | | Deputy Chief | | | 9-26-87 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | 111 Penn Street | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| Burial | | | 9-29-87 | | | Glen Haven | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Leonard J. Ruck, Inc. Baltimore, Maryland | | | SEP 28 1987 | | | John Swickard | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 96 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, WORKS, WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, CREMATION, REMOVAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

000001 SEP 28 1981

20% COTTON FIBER
MADE IN U.S.A.



SEP 28 1981

80372 OCT 14 87



(to: Mr. C. J. ...)

your letter of ...

Very truly yours,

2

cc: Mr. ...

cc: Mr. ...

065094 SEP 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked 9, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEE RUSSELL BETHEA | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 7 1987 | | | 2b. HOUR 9:45 AM | | | |
| 3. SEX MALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR 4-10-37 | | 6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS. | | 7. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 12. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 13. CITY OR TOWN OF DEATH BALTIMORE | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP | | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 16. KIND OF BUSINESS OR INDUSTRY | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE MARYLAND | | 17b. COUNTY BALTO | | 17c. CITY OR TOWN BALTO | | 17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17e. STREET ADDRESS / ZIP CODE 1303 EDMONDSON AVE 21223 | |
| 18. FATHER'S NAME FIRST MIDDLE LAST JAMES E. BETHEA | | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUKE MONTGOMERY | | 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 21. SOCIAL SECURITY NO. 212 26 2296 | | 22. INFORMANT ADDRESS Mrs. CORNE MONTGOMERY 1901 N. BANTON ST 21216 | |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SMALL CELL CARCINOMA of LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 24a. DATE OF OPERATION | | 24b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 24c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 26a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 26c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 27a. I certify that the (this hospital) attended the deceased from 8/17 , 19 87 , to 9/7 , 19 87 , that we (we) lost saw the deceased alive on 9/7 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (we) (did) not view the body after death. | | | | | | | | | |
| 27b. SIGNATURE Thomas S. Miller | | | | DEGREE MD | | | | 27c. DATE SIGNED 9/7/87 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS S. MILLER | | | | 27e. ADDRESS BON SECOURS HOSPITAL | | | | | |
| 28a. BURIAL, CREMATION, REMOVAL TYPE BURIAL | | 28b. DATE 9-11-87 | | 28c. NAME OF CEMETERY OR CREMATORY ARBITUS MEM PK | | 28d. LOCATION CITY OR TOWN COUNTY STATE BALTO Co. MD | | | |
| 29. FUNERAL DIRECTOR NAME JOSEPH L. RUSS | | | | ADDRESS 2222 W. NORTH AVE | | DATE REC'D. BY REGISTRAR SEP 9 1987 | | 30. REGISTRAR'S SIGNATURE John Davidson-Rodden | |

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SEP 08 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (page 4).

DHMH - 16 60M 7/84
(VRA 15, 4)

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STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN MAE BEVILLE | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 08 87 | | 2b. HOUR 9:19 A.M. | |
| 3. SEX Female | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 12 04 1912 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Schlosser | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Bundt | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 212 07 8340 | | 17. INFORMANT ADDRESS Leonard S. Beville 4535 Pen Lucy Rd. 21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) known biventricular heart failure DUE TO, OR AS A CONSEQUENCE OF (c) obstructive jaundice of ? etiology APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (his hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Hochuli | | | | 22c. DATE SIGNED 9/8/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hochuli | | | | 22e. ADDRESS St. Agnes Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | |
| 25. DATE REC'D. BY REGISTRAR SEP 10 1987 | | | | 25b. REGISTRAR'S SIGNATURE Julia Benson-Rodgers | | |

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SEP 10 1987

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25450

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|---|------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) James F. Biebl Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR September 13, 1987 | | | 2b. HOUR 4:23 PM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 85 | | 7. IF UNDER 1 YEAR MONTHS DAYS 85 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garden Village Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Mgr. Lord | | 12b. KIND OF BUSINESS OR INDUSTRY Balt. Laundry | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Rosedale | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1619 Weyburn Rd. 21237 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ignatius Biebl | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Vobel | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I Army | | 17. INFORMANT ADDRESS Margaret H. Biebl 1619 Weyburn Rd. 21237 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Arrest | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | (b) Progressive Congestive Heart Failure weeks | | |
| | | | | | | | | | (c) Arteriosclerotic Cardiovascular Disease years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple Strokes, recurrent Pneumonia, Nephrosclerosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 6/13/86 to 9/13/87 that (I) (we) lost saw the deceased alive on 9/10/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Albert B. Bradley | | | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert B. Bradley, M.D. | | | | | | 22e. ADDRESS 4900 Belair Road | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sep 17 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Road 21214 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Walter Brooks Biscoe | | 2a. DATE OF DEATH MONTH DAY YEAR 9 8 87 | | 2b. HOUR 11:25 P.M. | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 8 5 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Worker Aerospace | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Biscoe | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-10-6824 | | 17. INFORMANT ADDRESS Dundalk, Md. 21222 | |
| | | | | 8045 North Boundary Road | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Joseph Tomarelli | | DEGREE | | 22c. DATE SIGNED 9/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Tomarelli | | 22e. ADDRESS FSK Medical Center | | | |

| | | | | |
|---|--|------------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 12, 1987 | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | 23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Baltimore Md. |
| 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Dundalk, Md. 21222 | | | 25a. DATE REC'D BY REGISTRAR SEP 10 1987 | 25b. REGISTRAR'S SIGNATURE Julia... |

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WASHINGTON, D.C.

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DATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|------------------------------|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Samuel Duncan BLACK | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 14, 1987 | | | 2b. HOUR 5:03 ^A M | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 4 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice Pres. Mftg. Marine Products | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Glyndon | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE P.O. Box 187, Glyndon, Md. 21071 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Duncan Black | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Ridgely | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No - | | | | 16b. SOCIAL SECURITY NO. 212-10-9842 | |
| 17. INFORMANT Mrs. Celeste B. Black, 10501 Gore Mill Rd., | | | ADDRESS | | | | | | | | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> | | | | | | | | 21053 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 minutes | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis</i> | | | | | | | | | | 72 hours | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic lymphocytic leukemia renal failure hepatic failure</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>8/25</i> 19 <i>87</i> , to <i>9/14</i> 19 <i>87</i> , that (1) (we) lost saw the deceased alive on <i>9/14</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Frederick M. Gessner MD</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>9-14</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frederick M. Gessner MD</i> | | | | | | 22e. ADDRESS <i>600 N Wolfe St Balto Md 21205</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/17/87 | | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | | | 23d. LOCATION Pikesville Balto. Md. | | |
| 24. FUNERAL DIRECTOR J. E. Lowell Lemmon, 10 W. Padonia Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rudess</i> | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (see placard).

000001 26 1984

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

MYRTLE

G.

BLACKWELL

2a. DATE KNOWN ☒ OF
DEATH ESTI MATED ☐ 9 11 19 87

7b HOUR
M

3 SEX
FEMALE

4 RACE
BLACK

5 DATE OF BIRTH
MONTH DAY YEAR
2 19 15

6 AGE (IN YEARS)
(LAST BIRTHDAY)
72 YRS.

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN.

IF UNDER 24 HRS.

2c. DATE
PRONOUNCED
DEAD 9 11 19 87

7d HOUR
8:40
P M

7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Md.

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10 CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
300 S. Dallas Court

12a. USUAL OCCUPATION (TYPE OF WORK
OR INDUSTRY)
LAUNDRY (WORKING LIFE)

12b. KIND OF BUSINESS
OR INDUSTRY
N/A

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
MD

13b. COUNTY

BALTIMORE

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS
300 S. DALLAS COURT 21231

14. FATHER'S NAME
FIRST MIDDLE LAST

EMMANUEL

SMITH

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

AUGUSTA

MACK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

212-20-8001

17. INFORMANT
ADDRESS
ABIGAIL HARMON 300 S. DALLAS COURT

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an
death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion

ACTUAL
SIGNATURE

Dennis F. Smyth

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 9-12-87

EXAMINER'S NAME
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE
9/17/87

23c. NAME OF CEMETERY OR CREMATORY
MOUNT ZION CEMETERY

23d. LOCATION
CITY OR TOWN COUNTY STATE

LANSDOWNE MD

24. FUNERAL DIRECTOR
NAME

WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE

25a. DATE REC'D. BY REGISTRAR

SEP 16 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Rodgers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-1. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

08233 SEP 17 87

2086 COTTON FIBER

068466 OCT

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25454

| | | | | | | |
|--|--|---|---|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUSSELL THOMAS BLAKE SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 30, 1987 | | 2b. HOUR 2:55 M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR OCT 20, 1924 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 13a. STATE MARYLAND | | 13b. COUNTY DORCHESTER | | 13c. CITY OR TOWN EAST NEW MARKET | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HOWARD BLAKE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE HACKETT | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAIL CARRIER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 218-16-6702 | | 17. INFORMANT ADDRESS IRENE G. BLAKE, EAST NEW MARKET, MARYLAND | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal Varices</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alcoholism</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>210 min</u> <u>2 months</u> <u>>20 yrs</u> |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/28/87</u> to <u>9/30/87</u> , that (I) (we) lost saw the deceased alive on <u>9/30/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>move</u> the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Wafik El-Deiny</u> | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wafik El-Deiny | | 22e. ADDRESS 650 N. Wolfe St., Baltimore MD 21205 | | | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10-3-87 | | 23c. NAME OF CEMETERY OR CREMATORY EAST NEW MARKET CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE EAST NEW MARKET, DORCHESTER, MD | |
| 24. FUNERAL DIRECTOR NAME ZELLER FUNERAL HOME, EAST NEW MARKET, MD 21631 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 13 1987 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 48 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director must move carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

000-000-000-000

91

000-000-000-000

OCT 13 1961

066335 SEP 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25455

REG. NO.

| | | | | | | |
|--|--|---|---|---|--------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAMIE VIRGINIA BLUM | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20, 1987 | | 2b. HOUR 8:00P ^M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 26, 1896 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3022 Guilford Ave. 21218 | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress. | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing | | | | |
| 13a. STATE Maryland | | 13b. COUNTY 21218 | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret V. King | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT ADDRESS 21236 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | 19. SOCIAL SECURITY NO. 218-07-1088 | | 20. DONALD F. POSEY 9007 PERRYVALE RD. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 16, 1987, to 9/20/87, that (I) (we) lost saw the deceased alive on July 16, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) not know the body after death. | | 22b. SIGNATURE William F. Renner, M.D. | | 22c. DATE SIGNED 9/24/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Renner, M.D. | | 22e. ADDRESS 3222 St. Paul St. 467-7053 | | 22f. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 24, '87 | | 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PARK | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON | | 24b. ADDRESS 8521 LOCH RAVEN BLVD. | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1987 | | |
| 25b. REGISTRAR'S SIGNATURE Julia Borden | | 25c. COUNTY BALTIMORE CO. | | 25d. STATE MARYLAND | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

080332 SEP 55 81

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CHILGIN ROAD

WATERBURY CONNECTICUT

SEP 10 1955

WATERBURY

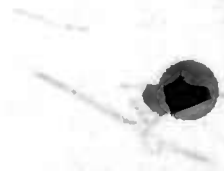
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required by the State is the death certificate executed within 24 hours of death. Post-mortem examination is required by the State. The low required by the State is the death certificate executed within 24 hours of death. Post-mortem examination is required by the State.

TO FUNERAL DIRECTOR: After this certificate has been completed, it should be detached for use as the burial permit permit. This copy is to be retained by the funeral director. Page 2 and 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. Important: If item 21 is marked or item 18 is marked, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | |
|---|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marjorie Agnes Boone | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/26/87 | | 2b. HOUR 5:40AM | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 1/13/07 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. (IN YEARS LAST BIRTHDAY) 80 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Johns Hopkins Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Brooklyn | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 5316 Wasena Avenue | | 21225 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herbert C. Sullivan | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Finnegan | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-22-0695 | | 17. INFORMANT ADDRESS Mr. Raymond Bunting 5302 Wasena Avenue Baltimore Maryland 21225 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) Urosepsis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 1 day 1 day | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Metastatic Thyroid cancer. Terminal cervical cancer | | | | | | |
| 19a. DATE OF OPERATION 1985 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Decreased renal function | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 19 , 19 87 , to Sept 26 , 19 87 , that (I) (we) last saw the deceased alive on 9/25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Dreg Calligaro | | | | 22c. DATE SIGNED 9/26/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Calligaro | | | | 22e. ADDRESS 600 N. WOLFE ST BALTO 21205 Johns Hopkins Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/29/87 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive U.M. Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore MD | | | | | | |
| 24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc 8728 Liberty Road Randallstown Maryland 21133 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randner | | |

084545 SEP 09 01



065421 SEP 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|------------------|--|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Carley Curtis Borrer | | | 2a. DATE KNOWN OF DEATH 8/26/1987 | | | 2b. HOUR 1:50 P M | | |
| 3. SEX male | 4. RACE White | 5. DATE OF BIRTH Dec. 7, 1933 | 6. AGE (IN YEARS) 53 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD 8/26/1987 | 7d. HOUR 1:50 P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 13a. STATE W.Va. | | | 13b. COUNTY Jefferson | | 13c. CITY OR TOWN Charles Town | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Brison Victor Borrer | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby Gladys Kimble | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 235-52-4724 | | 17. INFORMANT 203 Flowing Acres Rd. Eula Borrer- Charles Town W.Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Pancreatic Pseudocyst</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | ADDRESS 111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 8/31/87 | | 23c. NAME OF CEMETERY OR CREMATORY Rosedale Crematory | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley W.Va. | |
| 24. FUNERAL DIRECTOR NAME <i>Thomas J. Shanks</i> | | | ADDRESS 346 WHITEFIELD RD BART MD | | | 25a. DATE REC'D. BY REGISTRAR SEP 10 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Tidwell-Randall</i> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE (NO. 21301)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

002431 SEP 14 01

SEP 10 01

067589 OCT 5 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|--|
| 5a. DECEASED NAME (TYPE OR PRINT) FIRST (TIMMIE) MIDDLE LAST Timothy Bostic | | 2a. DATE OF DEATH MONTH DAY YEAR 9 / 28 / 87 | | 2b. HOUR 952P.M. | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11 / 19 / 52 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | 10. CITY OR TOWN OF DEATH Baltimore | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore VA Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing Assistant | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY Baltimore City | | 13c. CITY OR TOWN Baltimore | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 25 1/2 N. Fulton AVE 21223 | | 14. FATHER'S NAME FIRST MIDDLE LAST Richard Bostic | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Bostic | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 055-44-0362 | |
| 17. INFORMANT Hospital Records | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Acquired Immunodeficiency Syndrome APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes Days 2 yrs | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Thomas S. Wilson MD | |
| 22c. DATE SIGNED 9/28/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas S. Wilson MD | | 22e. ADDRESS 3900 Loch Raven Blvd, Bal | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | |
| 23d. LOCATION CITY OR TOWN COUNTY Owings Mills | | 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR OCT 02 1987 | |
| 25b. REGISTRAR | | 25c. REGISTRAR | | 25d. REGISTRAR | |

067282 OCT-287

OCT 02 1994

065986 SEP 17 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25459

REG. NO.

| | | | | | | | | | | | | | |
|---|--|-----------------|--|--|--|--|--|--|--|---|--|---|--|
| 1- STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD T BOWDEN | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 12 1987 | | 2b. HOUR M | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Aug 30 1940 | | 6 AGE IN YEARS (LAST BIRTHDAY) YRS. 47 | | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 12 1987 | | 2d. HOUR 10:43 AM | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp. (DOA) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker | | 12b KIND OF BUSINESS OR INDUSTRY Cabinet | | | |
| 13a STATE Maryland 13b COUNTY Anne Arundel 13c CITY OR TOWN Baltimore | | | | | | | | | | | | | |
| 13d INSIDE (CITY LIMITS?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e STREET ADDRESS 5111 4th Street 21225 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William L. Bowden | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen V. Smith | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b SOCIAL SECURITY NO. 219-38-0092 | | | | 17 INFORMANT ADDRESS Betty L. Zeller Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 9-13-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md | | | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

SEP 17 1987
FURNITURE SIGNATURE

062308 SEP 17 81

20X COLLOIDAL SILVER

11/11/81

066232 SEP 18 1987

FOR
STATE
REGISTRAR CARRIE M. BOWENSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25460

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CARRIE MARIE BOWEN | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/17/87 0535 A | | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 11, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN CATONSVILLE | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY FINK | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE KEMPE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 100-09-6179D | | 17. INFORMANT ADDRESS 229 STONEY HOLLOW RD. GREENLAWN, N.Y. 11740 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTICEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>MEMBRANE BRIST LUNGINOMA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u> <u>Months</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>87</u> , to <u>9/17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>M. Shortman</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9/17</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. SHORTMAN</u> | | 22e. ADDRESS <u>St Agnes Hospital</u> <u>900 Caton Ave Baltimore Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 9/21/87 | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME BERRY & RUSSELL C. WITZKE FUNERAL HOME | | | 25. DATE REC'D. BY REGISTRAR SEP 18 1987 | | |
| 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | 25b. REGISTRAR'S SIGNATURE <u>Julian Davidson-Randall</u> | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

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REC'D CIVIL LIBERTY

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ALBANY, N.Y.

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066374 SEP 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25461

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Pearl Lena Bowen | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 17 87 | | | 2b. HOUR 4 ³⁵ AM | | | |
| 3. SEX Female F | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 19 89 | | 6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Marland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Helen Madison Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Landstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2535 Research Ave 21227 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Bowen | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Marie Talbort | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-2229 | | 17. INFORMANT'S NAME AND ADDRESS Leland T. Bowen 4134 Hyden Ct. Baltimore, Md. 21225 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.H.F. + M.I.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/5/87 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Colostomy repair</u> | | | | | | | | | |
| 19a. DATE OF OPERATION 9/1/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Colostomy repair</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 8/29, 1987, to 9/17, 1987, that (I) (we) last saw the deceased alive on 9/17, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Leland T. Bowen | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/17/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT FRANCIS | | | | 22e. ADDRESS Liberty Medical Center Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-19-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Waters Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE St Leonard Calvert md. | | | |
| 24. FUNERAL DIRECTOR NAME Donald V. Borgwardt Port Republic, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Decker | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP

[Faint, mostly illegible text, possibly a memorandum or report, with some visible words like "subject", "information", and "reference".]

065136 SEP 10 1987

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH25462
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | |
|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SOLOMON BOYARSKY | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1, 1987 | | 2b. HOUR 8A. M | | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 4, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 524 N. CHARLES ST., APT. 1713 (21202) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED WINDOW CLEANER | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN BOYARSKY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHEL UNKNOWN | | | | 13e. STREET ADDRESS / ZIP CODE 524 N. CHARLES ST., APT. 1713 (21202) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-14-6900 | | 17. INFORMANT ADDRESS MRS. ROSALIE LAZARUS 3119 WALNUT AVE. 21117 | | | | 17b. KIND OF BUSINESS OR INDUSTRY | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Other described Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Polyarthritis Kidney & fracture</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>17 July 87</u> to <u>1 Sept 87</u> , that (I) (we) last saw the deceased on <u>17 July 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Gary B. Ruppert</u> | | | | DEGREE <u>MD</u> | | | | 22c. DATE SIGNED <u>9/1/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY B. RUPPERT | | | | 22e. ADDRESS 301 ST. PAUL PL. 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY CHERNIGOVER CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 09 1987 | | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Gary B. Ruppert</u> | | | | | | | | | |

BP

002130 259 10 87

066906 SEP 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Boyd | | MIDDLE REBECCA | | 2a. DATE OF DEATH MONTH DAY YEAR 9-22-87 | | 2b. HOUR 4:30 AM | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 10 10 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED. CTN. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPING | | 12b. KIND OF BUSINESS OR INDUSTRY JHH | |
| 13a. STATE MD | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JEFF BOYD | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TENNIE HENDRICK | | 13e. STREET ADDRESS / ZIP CODE 401 EAST 25th STREET 21218 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 217-16-5149 | | 17. INFORMANT ADDRESS CARROLL BOYD 1602 NORMAL AVENUE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic renal failure | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months < 24 hrs Months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-20, 1987 , to 9-22, 1987 , that (I) (we) last saw the deceased alive on 9-21, 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bennett, MD | | | | 22e. ADDRESS 5200 Eastern Ave Balto 21224 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL CO. MD | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. | | | | ADDRESS 1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR SEP 25 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows body injury, or other traumatic event, the medical examiner must be notified at once.

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CITY

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ON R. 111

1155 1155 1155 1155

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066221 SEP 18 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the box provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Robert | | MIDDLE EARL | | LAST Boyd | | 2a. DATE OF DEATH MONTH DAY YEAR 09 14 87 | | 2b. HOUR 7:31 PM | |
| 3 SEX MALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR 9 15 1935 | | 6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 72 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) THOMPSON | | 12b. KIND OF BUSINESS OR INDUSTRY STEEL | | | |
| 13a. STATE MD | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN DUNDALK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 7654 OLD BATTLE GROVE RD 21222 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Z. E. BOYD | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA ROGERS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES | | 16b. SOCIAL SECURITY NO. 234-56-6911 | | 17. INFORMANT ADDRESS BEN BOYD 8231 ROSE BANK AVE 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Metastatic Bronchogenic Carcinoma years DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: History of Head + Neck Carcinoma. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/11 87 9/14 87 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/14 19 87 to 9/14 19 87, that (I) (we) last saw the deceased alive on 9/14 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Nevin W. Todd, MD | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/14/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nevin W. Todd M.D. | | | | | | 22e. ADDRESS 301 St. Paul Place Balt. MD 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY OAKLAWN | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD | | 25a. DATE REC'D BY REGISTRAR SEP 18 1987 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS CONNELLY FUNERAL HOME OF DUNDALK | | | | | | 25b. REGISTRAR'S SIGNATURE Julia Dandora-Randall | | | | | |

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Handwritten notes and signatures, including a large signature at the bottom center.

065829 SEP 16 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANGEL C BRACETTY | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 11, 1987 | | | 2b. HOUR A 2:01 M | | |
| 3. SEX Male | | | 4. RACE Hispanic | | | 5. DATE OF BIRTH MONTH DAY YEAR 10 1 27 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction | | |
| 13a. STATE Md. | | | 13b. COUNTY Balto | | | 13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Manuel Santana | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phillida Bracetty | | | 13d. STREET ADDRESS / ZIP CODE 724 N. Collington Ave., 21205 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 581-01-2189 | | | 17. INFORMANT ADDRESS Rowena F. Bracetty, 724 N. Collington Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>abdominal carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anemia, alcohol abuse, interstitial lung disease</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11 Sept 87</u> to <u>11 Sept 87</u> that (I) (we) last saw the deceased alive on <u>11 Sept 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>B. Yoker</u> | | | | | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/11/87</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. Yoker</u> | | | | | | 22e. ADDRESS <u>Johns Hopkins Hospital</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIES Burial | | | 23b. DATE 914-87 | | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Prk | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Maryland | | | 24. FUNERAL DIRECTOR NAME ADDRESS Gary L. Kaufman 5695 Main St. Elkridge, Md. | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | |
| 25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u> | | | | | | | | |

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

DELLA

MIDDLE

LAST

BRANDOW

2a. DATE OF DEATH

Sept 27, 87

MONTH DAY YEAR

2b. HOUR

5:30 AM

3. RACE

black

5. DATE OF BIRTH

MONTH

DAY

YEAR

2

9

15

6. AGE (IN YEARS LAST BIRTHDAY)

72

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

Va

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore city

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Lincoln Nursing Home

12a. USUAL OCCUPATION

Disabled

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

2141 W. Vine St

21223

14. FATHER'S NAME

Alphonzo

MIDDLE

LAST

Barts

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Paige

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

083-26-6083A

17. INFORMANT

Barbara Ladson

ADDRESS

3800 Edgerton Rd

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio-Vascular Collapse

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic Renal Failure

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c) Diabetes Mellitus

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORKNOT WHILE ☐ AT WORK

21e. PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

A. I. Baykaler

DEGREE

MD

ATTENDING

MEDICAL

STAFF

PHYSICIAN ☒DIRECTOR ☐PHYSICIAN ☐

22c. DATE SIGNED

9-27-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

A. I. BAYKALER

22e. ADDRESS

831 Poplar Grove St - Baltimore

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

10/2/87

23c. NAME OF CEMETERY OR CREMATORY

Mt Zion Cemetery

23d. LOCATION

Landsdown

COUNTY

MD

24. FUNERAL DIRECTOR

NAME

Wm. C. March F/H West 4300 Wabash Avenue

ADDRESS

25a. DATE REC'D. BY REGISTRAR

OCT 02 1987

25b. REGISTRAR'S SIGNATURE

Julia Tisdale-Pendall

065202 OCT-281



CHATELAIN

BRAND

20% COTTON FIBER

OCT 28 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 5 4 6 7
DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 9-25-87
DATE PRONOUNCED DEAD 9-25-87 2:35 PM

1- STATE REGISTRAR

DECEASED NAME (TYPE OR PRINT)

FIRST

MIDDLE

LAST

JAMES

D.

BRANDT

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR 5 6 68

6. AGE (IN YEARS)

LAST BIRTHDAY 19 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Balto.

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

University Hospital STU

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Auto Mechanic

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Anne Arundel

13c. CITY OR TOWN

Millersville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

8315 Brookwood Rd. #21108

Millersville, Md.

14. FATHER'S NAME

FIRST

David

MIDDLE

E.

LAST

15. MOTHER'S MAIDEN NAME

FIRST

Carolyn

MIDDLE

L.

LAST

Grove

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

217-72-7454

17. INFORMANT

Mr. David E. Brandt

Md. #21108

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

8809

IMMEDIATE CAUSE (a)

Multiple injuries with complications

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR 1AM 9-4-87 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

subject fell through open stairwell of house under construction

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

construction site

21f. LOCATION

West Pasadena Rd. Anne Arundel Co., Md.

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐

Inspection ☒

Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☐

Accident ☒

Suicide ☐

Homicide ☐

Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Deputy Chief

DATE SIGNED 9-26-87

EXAMINER'S NAME (TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

9-29-87

23c. NAME OF CEMETERY OR CREMATORY

Crestlawn Cemetery

23d. LOCATION (CITY OR TOWN)

COUNTY

Howard

STATE

Md.

24. FUNERAL DIRECTOR

G. TROMAN SCHWAB

ADDRESS

3151 BALTO. NATL PIRE. #21229

25a. DATE REC'D BY REGISTRAR

OCT 1 1987

25b. REGISTRAR'S SIGNATURE

Julia D. Rindall

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM-3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

001:03 COL-581

20% COTTON 50% FIBER

MADE IN THE U.S.A.



MADE IN THE U.S.A. 100% COTTON 50% FIBER

66598 SEP 24 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25468

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALMA BRASHEAR | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 19 87 | | 2b. HOUR 11 P M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 10 17 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | 12b. KIND OF BUSINESS OR INDUSTRY self | |
| 13a. STATE Maryland | 13b. COUNTY | 13c. CITY OR TOWN Brooklyn | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4113 6th Street 21225 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George C. Diehl | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida S. Balty | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 263-46-8989 | | 17. INFORMANT ADDRESS Ruth Hall 4113 6th St. Brooklyn, Md. 21225 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Senile dementia | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8/31 87 9/19 87 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31 19 87 to 9/19 19 87 , that (I) (we) last saw the deceased alive on 9/19 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kuang-Yen Huang | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG | | 22d. ADDRESS Bon Secours Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/22/87 | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Md. |
| 24. FUNERAL DIRECTOR NAME Ambrose Funeral Home, Inc. | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1987 | | |
| ADDRESS 1328 Sulphur Spr. Rd | | | 25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (You please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified by print.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALICE PEARL BREWER | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-22-87 | | | 2b. HOUR 1230 PM | | | |
| 3. SEX Female | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR May 4 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON Hosp. & MED. CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE M.D. | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Westley Blackwell | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelia Cane | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 214-40-7171 | | | 17. INFORMANT ADDRESS Ellen Simon 5418 Northwood Dr 21212 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) vascular collapse - cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Recent GT bleeding DUE TO, OR AS A CONSEQUENCE OF (c) homicide Approximate interval between onset and death: minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Parkinson's Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 9/15/87 to 9/22/87 , that (we) last saw the deceased alive on 9/22/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE J.R. Gladue, MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 9/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.R. Gladue | | | | | | 22e. ADDRESS South Charles St | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | | 23b. DATE 9-26-87 | | 23c. NAME OF CEMETERY OR CREMATORY MT Zion Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CITY MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Rest Funeral Home 5204 York Rd | | | | | | SEP 28 1987 J. Gladue | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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065998 SEP 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25 470
25 470
REG. NO.

1- STATE REGISTRAR

| | | | | | | | | | | | | | | |
|--|---------|------------------|---|-------------------|---------------------|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF ESTI. MATED | | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| LOUISE A. BRICHETTO | | | 9 13 1987 | | | 9 13 1987 | | | 9 13 1987 | | | 6:10 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| F | Cauc | Feb 3 1905 | 82 YRS. | | | Baltimore City | | | | | | | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 11. CITIZEN OF WHAT COUNTRY? | | | 12. MARRIED | | | 13. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD | | | USA | | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Baltimore City | | | MD | | |
| 14. CITY OR TOWN OF DEATH | | | 15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 17. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | 135 N. Streeper St. | | | Housewife | | | Own Home | | | | | |
| 18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 19. INSIDE CITY LIMITS? | | | 20. STREET ADDRESS | | | | | | | | |
| 13a. STATE MD | | | 13b. COUNTY | | | 13c. CITY OR TOWN Balto | | | 13d. STREET ADDRESS 21224 135 N. Streeper St. | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 17. SOCIAL SECURITY NO. | | | 18. INFORMANT ADDRESS | | |
| Harry | | | Anna | | | No | | | 213-74-0513 | | | Eunice Vollmer 8224 Long Point Rd | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Smoke inhalation | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | |
| | | | 5:45pm 9-13-1987 | | | House fire. | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | |
| | | | house | | | 135 N. Streeper St., Balto. City MD | | | | | | | | |
| 22a. I certify that I took charge of the remains described above held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| 22b. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> (TITLE SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 9-13-87 | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | | |
| Burial | | | 9/17/87 | | | Gardens of Faith | | | Balto Md | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE OF RECORD | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| John A. Moran Inc. | | | 3000 E. Balto. St. | | | SEP 16 1987 | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

00288 932 17 31

066901 SEP 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eleanor R Briggs | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 22 87 | | 2b. HOUR 10:05 PM | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 10 30 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRESSOR | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert NMI Hicks | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella NMI Wilson | | 13e. STREET ADDRESS / ZIP CODE 536 N Carrollton Ave. 21223 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 220-14-5894 | | 17. INFORMANT ADDRESS Byrdell Stewart 536 N. Carrollton Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Metastatic Bladder Cancer DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/22 , 19 87 , to 9/22 , 19 87 , that (I) (we) lost saw the deceased alive on 9/22 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE S. McCormack MD | | | | DEGREE MD | | 22c. DATE SIGNED 9/22 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. McCormack MD | | | | 22e. ADDRESS 22 S. Greene St. Baltimore, Md 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY KING MEM. PK. CEMETERY RANDALLSTOWN | | 23d. LOCATION CITY OR TOWN COUNTY STATE MD | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE | | | | 25. DATE RECEIVED BY REGISTRAR SEP 25 1987 | | 26. REGISTRAR'S SIGNATURE Julia Schmitt-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The permit, name carbon papers, pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

082201 SEP 28 01

Handwritten notes and diagrams on a grid background. The text is mostly illegible due to blurring and bleed-through. Some visible fragments include:

- Top right: 082201 SEP 28 01
- Top center: 082201 SEP 28 01
- Top left: 082201 SEP 28 01
- Center: 082201 SEP 28 01
- Bottom: 082201 SEP 28 01

There are also several small, illegible handwritten notes scattered throughout the grid.

066267 SEP 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph W. Briggs Sr.</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9-15-87</i> | | | 2b. HOUR <i>12:45</i> M | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>BLACK</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>10-30-10</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>76</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. CITY</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>BALTO.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BON SECOURS Hosp.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>PORTER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>KOHN CO. HOCHSCHILD</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i> | | 13b. COUNTY <i>BALTIMORE</i> | | 13c. CITY OR TOWN <i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>JOSEPH BRIGGS</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY ELIZABETH TAYLOR</i> | | 16. SOCIAL SECURITY NO. <i>214-20-6886</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO.</i> | | 16b. SOCIAL SECURITY NO. <i>214-20-6886</i> | | 17. INFORMANT <i>MRS. KATIE E. BRIGGS</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest.</i> | | DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Hypertension Post Stroke Seizures Hypothyroidism, pneumonia, Dysphonia.</i> | | | | | | | |
| 19a. DATE OF OPERATION <i>9/11/87</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Seizures</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9/11/87</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) <i>3455, Wilkens Ave, Balto, Md</i> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>3455, Wilkens Ave, Balto, Md 21224</i> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/11/87</i> to <i>9/15/87</i> , that (I) (we) lost saw the deceased alive on <i>9/15/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>K. Dang</i> | | | | 22c. DATE SIGNED <i>9/15/87</i> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KOMAL K. DANG M.D.</i> | |
| 22e. ADDRESS <i>3455, Wilkens Ave, Balto, Md 21224</i> | | | | 22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KOMAL K. DANG M.D.</i> | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|-------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>9/19/1987</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>ARBUTUS MEM. PARK</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE, MARYLAND</i> | |
| 24. FUNERAL HOME <i>NUTTER FUNERAL HOMES, INC.</i> | | | | 25. DATE REC'D BY REGISTRAR <i>SEP 17 1987</i> | | | |
| 25a. ADDRESS <i>2501 GWYNNS FALLS PKWY, BALTIMORE, MD. 21216</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The funeral director should have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to issuance of a permit for burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 16b, Film G632 10-2-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

067240 SEP 30 1987

| | | | | | |
|--|--|--|--|--|--------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED'S NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOUR MIN. | |
| Clarence B. Briscoe, Sr. | | 9-25-87 | | 8:44 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| male | black | MONTH DAY YEAR | 72 YRS | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| N.J. | USA | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | Shaw Hospital | retired | I.R.S. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. STATE | 13c. COUNTY | 13d. CITY OR TOWN | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13f. STREET ADDRESS / ZIP CODE |
| | MD | Balt Co. | Baltimore | | 515 Alter Avenue 21208 |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | |
| Ambrose | Clara Johnson | Yes WWII 218-01-8067 | | | |
| 17. INFORMANT | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | |
| Mrs. Janie Briscoe | IMMEDIATE CAUSE (a) Undifferentiated Lung CA | | | | |
| 515 Alter Ave. | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | |
| | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| chronic renal failure, ankylosing spondylitis | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| | 19 | N/A | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | N/A | N/A | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-10-87 to 9-25-87, that (I) (we) last saw the deceased alive on 9-25-87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | |
| Maury J. Nyoku | MD | 9-25-87 | Maury J. Nyoku | | |
| 22e. ADDRESS | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | |
| Shaw Hospital, Belvedere at Greenway | Burial | | | | |
| | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| | 9-30-87 | Druid Ridge | Ba Ho Md. | | |
| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | | | |
| Jas. A. Morton & Sons 1701 Laurens St. | SEP 28 1987 | Julia Davidson-Randall | | | |

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used to analyze the data, and the results of the analysis. The third part of the report is a discussion of the results of the study and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

065861 SEP 16 1987

 Item 13 per phone
 FOR STATE REGISTRAR
 9/18/87 DRD

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

 87 25494
 REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Babyboy Brockington | | | 2a. DATE OF DEATH MONTH DAY YEAR 8 24 87 | | | 2b. HOUR 3:55 AM | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 8 23 87 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 10 13 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE Md. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lamont Butler | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dana Brockington | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | | | | | |

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) _____

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

 Conditions, if any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause last

(b) _____

extreme immaturity/prematurity

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael L. Zuckloffer | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 8/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL L. ZUCKLOFFER | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL CREMATION REMOVAL (SPECIFY) | | 23b. DATE 8-25-87 | | 23c. NAME OF CEMETERY OR CREMATORY Sinai Hospital | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD | |
| 24. FUNERAL DIRECTOR NAME Sinai Hospital 2401 W. Belvedere Ave | | | | 25. DATE REC'D. BY REGISTRAR SEP 15 1987 | | | |
| | | | | 25. REGISTRAR'S SIGNATURE Julia Gordon-Randall | | | |

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RECEIVED

OFFICE

065143 SEP 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

25475

| | | | | | |
|---|---|---|--|---------------------------------------|---------------------------------------|
| 1. STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) DR. JACK BRODY | | SEPT. 3, 1987 | | 2:55 P.M. | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH OCT. DAY 12 YEAR 1919 | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) DENTIST | 12b. KIND OF BUSINESS OR INDUSTRY DENTISTRY | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTO 13c. CITY OR TOWN PIRESVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3309 MARNAT RD. (21208) | | |
| 14. FATHER'S NAME FIRST IRVING MIDDLE BRODY LAST BRODY | | 15. MOTHER'S MAIDEN NAME FIRST LILLIAN MIDDLE BRODY LAST BRODY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE BRANCH AND DATES) YES WWII ARMY | | 16b. SOCIAL SECURITY NO. 194-16-9386 | 17. INFORMANT ADDRESS MRS. GLORIA BRODY 3309 MARNAT RD. (21208) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-31 19 82 to 9-3 19 82 that (I) (we) last saw the deceased alive on 8-31 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Stanley R. Steinbach | | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/4/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY R. STEINBACH | | 22e. ADDRESS 178 LADG 2120 R | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 9/4/87 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CEM | 23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN, BALTO, MD. | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | | 25a. DATE REC'D. BY REGISTRAR SEP 09 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodell | | | |

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SEP 08 1987

066760 SEP 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25476

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLARENCE BROGDON | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 21, 1987 | | 2b. HOUR 11:50PM |
| 3. SEX M | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR 4 9 12 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | 12b. KIND OF BUSINESS OR INDUSTRY Belt Steel |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN BALTO | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harvey Rhames | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA GALLAWAY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-07-1591 | | 17. INFORMANT ADDRESS JOHN RHAMES 1645 Woodbourne | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PARKINSONS DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one minute one day | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1 19 87 , to 9/21 19 87 , that (we) last saw the deceased alive on 9/21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert Reimer | | DEGREE MD | | 22c. DATE SIGNED 9/22/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT REIMER | | 22e. ADDRESS 600 NORTH WOLFE ST. BALTIMORE JOHNS HOPKINS HOSPITAL MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/26/87 | 23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD | |
| 24. FUNERAL DIRECTOR NAME LOCKS FUNERAL HOME | | ADDRESS 1304 N. Central | | 25. DATE REC'D. BY REGISTRAR SEP 24 1987 | 25b. REGISTRAR'S SIGNATURE Julia Benson-Lindner |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician, it can be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. The attending physician must remove carbon copies, pages 1 and 2, and they should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. It is the responsibility of the funeral director to ensure that the death certificate is properly filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked on item 18, show date, time, and place of injury or trauma on item 21.

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The objectives of the project are stated in clear, concise terms.

2. The second part of the report is a description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used to analyze the data, and the methods used to validate the results.

3. The third part of the report is a description of the results of the study. This includes a description of the data collected, a summary of the statistical analysis, and a discussion of the results in relation to the objectives of the project.

4. The fourth part of the report is a conclusion and a list of recommendations. The conclusion summarizes the findings of the study and the recommendations provide suggestions for future research.

5. The fifth part of the report is a list of references. This includes a list of all the sources used in the study, including books, articles, and other documents.

064994 SEP-98

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) VERNON E. BROOKS | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 02 87 | | 2b. HOUR 7:09 P.M. |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 5 27 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED TRUCK DRIVER | 12b. KIND OF BUSINESS OR INDUSTRY UNION 551 | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTO, MD. | 13d. STREET ADDRESS / ZIP CODE 441 LORRAINE AVE. 21218 |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES BROOKS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA HEBRON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 214-01-5537 | | 17. INFORMANT MR. BALTIMORE, MD. 21229 VERNON W. BROOKS 1003 LYNDAURST ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8/5 87 9/02 87 | |
| 22a. I certify that (I) (the hospital) attended the deceased from 8/5 19 87 to 9/02 19 87 that (I) (we) last saw the deceased alive on 09/02 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE KUANG-YEN HUANG MD | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG | | 22e. ADDRESS BON SECOURS Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/8/1987 | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. |
| 24. FUNERAL HOME NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTO, MD. 21216 | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1987 | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and fill with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

065533 SEP 5 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|--|--|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Brown | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 9 87 | | 2b. HOUR 5 10 P.M. | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 12 13 07 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 79 | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Ctr. | | 9. BALTIMORE CITY OR COUNTY OF DEATH City Baltimore City MD. | | |
| 13a. STATE Mo. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 419 S. Robinson Street 21224 | | 12b. KIND OF BUSINESS OR INDUSTRY Hairdresser | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hairdresser | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NBO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS August W. Brown 419 S. Robinson Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 48 hr | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-7 , 19 87 , to 9-9 , 19 87 , that (I) (we) last saw the deceased alive on 9-9 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Francis McMahon MD | | DEGREE MD | | 22c. DATE SIGNED 9/9/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. McMahon, MD | | 22e. ADDRESS Francis Scott Key Medical Center | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-14-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | | | | |
| 24. FUNERAL DIRECTOR NAME JOHN M. WEBER & SONS INC 401 S. CHESTER STREET | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | |

MEDICAL CERTIFICATION

9

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

002233 SEP 12 85

RECEIVED STATION 8192

SEP 14 1985

Lab. 1111 - 11/11/85

Doc 1052

SEP 14 1985

067517 OCT

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 287 Daisy Mae Brown | | | 7a. DATE OF DEATH MONTH DAY YEAR 9 29 87 | | 7b. HOUR 6:30 A.M. |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 12 25 18 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY N/A |

| | | | | | |
|--|--|--|--------------------------------|---|---|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | 13b. COUNTY Balto | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2713 Mt. Holley St. 21229 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jack Price | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Thompson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 207-20-1914 | 17. INFORMANT ADDRESS John Brown 2713 Mt. Holley St. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Chronic gastro intestinal Bleeding

DUE TO, OR AS A CONSEQUENCE OF

(c) Adenocarcinoma of colon with metastasis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | |
|------------------------|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|--|--|---|

| | | |
|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |
|--|--|--|

| | | |
|--|--|---|
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|--|--|---|

22a. I certify that (I) ~~this hospital~~ attended the deceased from 9/15 19 87, to 9/29 19 87, that (I) ~~lost~~
saw the deceased alive on 9/29 19 87, and that in (my) ~~our~~ opinion death occurred on the date and hour and from the causes stated
above, (I) ~~we~~ did not view the body after death.

| | | | |
|--------------------------------------|--------------|--|-----------------------------|
| 22b. SIGNATURE Rafael E. Espinosa | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 9/29/87 |
|--------------------------------------|--------------|--|-----------------------------|

| | |
|---|---|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafael E. Espinosa | 22e. ADDRESS 3001 S. Hanover St. Balt MD |
|---|---|

| | | | |
|--|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 10/3/87 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD |
|--|----------------------|--|---|

| | | | |
|--|---------------------------------|---|---|
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. | ADDRESS 1101 F. NORTH AVENUE | 25a. DATE REC'D. BY REGISTRAR OCT 1 1987 | 25b. REGISTRAR'S SIGNATURE Julia Dindon-Rudner |
|--|---------------------------------|---|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

085213 OCT-58

OCT-58

66118 SEP 18 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | |
|--|--|---|---|--|--------------------------------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ERIC BROWN JR. | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 13, 1987 | | 2b. HOUR P 2:25 M | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 1, 1987 | | 6. AGE (IN YEARS LAST BIRTHDAY) 5 MONTHS YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ERIC A BROWN, SR. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GAIL BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS ERIC A BROWN, SR. 2717 GAEHOUSE DR 21207 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Severe heart failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Chronic lung disease of prematurity 5 1/2 months

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

10 min

48 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Acute renal failure/chronic renal failure

| | | | | | | | |
|------------------------|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|--|--|---|--|

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
|---|--|--|--|---|--|--|--|

| | | | | | |
|--|--|--|--|---|--|
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
|--|--|--|--|---|--|

22a. I certify that (I) (this hospital) attended the deceased from 4/1 19 87, to 9/13 19 87, that (I) (we) lost
above, (I) (we) (did) (did not) view the body after death.

| | | | | | | | | |
|---------------------------------------|--|--|--------|--|--|-----------------------------|--|--|
| 22b. SIGNATURE <u>M. Moll M.D.</u> | | | DEGREE | | | 22c. DATE SIGNED 9/13/87 | | |
|---------------------------------------|--|--|--------|--|--|-----------------------------|--|--|

| | | | | | |
|--|--|--|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MOLL, M.D. | | | 22e. ADDRESS Johns Hopkins Hospital White St Baltimore, MD 21205 | | |
|--|--|--|--|--|--|

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY MARYLAND NATIONAL LAUREL | | 23d. LOCATION CITY OR TOWN COUNTY STATE M.D. | |
|--|--|----------------------|--|--|--|--|--|

| | | | | | |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR NAME REDD FUNERAL HOME 5209 YORK RD 21212 | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Deaton-Rodgers | |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon page 4 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, mostly illegible text covering the page, possibly a letter or report. The text is too light to transcribe accurately.]

067229 SEP 30 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis A. Brown | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 23 87 | | 2b. HOUR MIN. 8:15 A |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 04/03/27 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven VAMC | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY CORRY'S WINE & |
| 13a. STATE MARYLAND | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE BALTO. MO. 1581 STONEWOOD RD. 21239 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HOWARD BROWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AUGUSTA GASSAWAY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII | | 16b. SOCIAL SECURITY NO. 219 22 2073 | 17. INFORMANT MRS. CLARICE V. BROWN BALTIMORE, MD. 21239 1581 STONEWOOD ROAD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) squamous cell carcinoma of tongue DUE TO, OR AS A CONSEQUENCE OF and oropharynx (c) 14 months | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: cachexia | | | | | |
| 19a. DATE OF OPERATION 8/1986 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Squamous cell CA tongue | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/15 , 19 87 , to 9/23 , 19 87 , that (I) (we) last saw the deceased alive on 9/23 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Raymond S. Hoffman | | DEGREE MD | | 22c. DATE SIGNED 9/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND S. HOFFMAN | | 22e. ADDRESS 861 Hollins Street, Baltimore, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/28/1987 | 23c. NAME OF CEMETERY OR CREMATORY CARRISON FOREST VET. COM | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND |
| 24. FUNERAL HOME NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY, BALTO, MD. 21216 | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 | | | |
| | | 25b. REGISTRAR'S SIGNATURE John Seiden-Randall | | | |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK A. BROWN JR | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 12 87 | | 2b. HOUR 9 P.M. | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR DEC 14 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES AMERICA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MT. VERNON CARE CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY HANDY MAN | |
| 13a. STATE MD. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK BROWN SR. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie BARNES | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 219-01-2181 | |
| 17. INFORMANT PATRICE TURNER | | ADDRESS 2550 CECIL AVE. | | 13e. STREET ADDRESS / ZIP CODE 311 S. Bethel Street 21231 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/10/87</u> to <u>9/12/87</u> , that (I) (we) last saw the deceased alive on <u>8/10/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/12/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR RUBEN REIDER | | | | 22e. ADDRESS 7445 FURNACE BLANCH RD Blk B Unit 2106 | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE LANSDOWNE, MD | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H. INC. 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D BY REGISTRAR SEP 15 1987 | | | |

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100% COTTON

20% COTTON FIBER

100% COTTON

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|--|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jeremiah Brown | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-28-87 | | 2b. HOUR 9:00 AM | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10-31-13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5016 Denmore Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Tom Brown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Whitfield | | 13e. STREET ADDRESS / ZIP CODE 5016 Denmore Avenue 21215 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 223-10-8213 | | 17. INFORMANT ADDRESS Joann Curry 5016 Denmore Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Diffusely METASTATIC Colon Cancer DUE TO, OR AS A CONSEQUENCE OF with HEpatic Failure (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks 7 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) this hospital attended the deceased from 9/2 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (if two) (add and not view the body after death). | | | | | | |
| 22b. SIGNATURE A. Goldsberg | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/30/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Goldsberg | | 22e. ADDRESS 6804 Park Heights Ave | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-02-87 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland |
| 24. FUNERAL DIRECTOR NAME Brown/Thompson Funeral Home | | | | ADDRESS P.O. Box 4433 | | 25a. DATE REC'D. BY REGISTRAR OCT 2 1987 |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

007078 Oct-88

DEBIT NOTATION

UNIVERSITY

University of California
San Diego
La Jolla, CA 92037

Dr. J. D. Smith
Department of Biology
University of California
San Diego

10/10/88

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|------------------------------------|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | |
| John L. Brown | | | | | | | | | | DATE OF ESTI-MATED <input checked="" type="checkbox"/> 9 10 19 87 | | 7b. HOUR M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| male | | black | | 8 MONTH DAY YEAR 8 3 1929 | | 58 YRS. | | MONTHS DAYS | | HOURS MIN | | 9 10 19 87 | | 6:07 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md | | | | U S A | | | | | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | 1602 N. Hilton Street | | | | Cab Driver | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1602 N. Hilton Street Apt T1 21216 | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Lewis | | | | Brown | | | | Eula | | | | Thomas | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| Yes | | | | 214-26-2084 | | | | Rosalee Ruffin 2912 Westwood Avenue | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive & arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | MEDICAL EXAMINER | | | | | | | |
| Charles P. Kokes, M.D. | | | | 111 Penn St. | | | | Balot.MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 9/15/87 | | Mt Zion Cemetery | | | | Landsdown MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H West 4300 Wabash Avenue | | | | | | | | SEP 14 1987 | | | | Julia [Signature] | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))

002000 SEP 12 61



SEP 14 1961

067397 OCT 1 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

075 08 79
BROWN, JOSEPH W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director's office. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| JOSEPH W BROWN | | | | | SEPTEMBER 24, 1987 | | | 10:35P _M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | BLACK | | MONTH 4 DAY 24 YEAR 24 | | 63 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| SC | | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | | | N/A | | N/A | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| | | MD | | BAL TO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 530 E. 35th STREET 21218 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| JIM | | BRYANT | | ELLA BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| NO | | 250-30-8669 | | FLORA BROWN | | 530 E. 35th STREET | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung Cancer</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>1 year</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>9/16/1987</u> to <u>9/24/87</u> , that (I) (we) last saw the deceased alive on <u>9/24/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>John D. Hummel</u> | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Hummel | | | | 22e. ADDRESS 600 N. Wolf St. Baltimore, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY STATE | |
| BURIAL | | 10/1/87 | | BALTIMORE CEMETERY | | BALTIMORE | | MD | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| WM. C. MARCH F/H, INC. | | | | 1101 E. NORTH AVENUE | | SEP 30 1987 Julia Davidson-Randall | | | |

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2586

| | | | | | | | | |
|--|-------------------------|---|--|---|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) LARRY W. BROWN | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9-9-87 19 | | | 2b. HOUR M | | |
| 3. SEX MALE | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR 10-14-53 | 6. AGE (IN YEARS) LAST BIRTHDAY 31 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-9-87 19 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2237 Brookfield Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2237 Brookfield Ave 21317 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Woodrow E. Brown | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brenda Clements | | | ADDRESS Reisterstown Rd. 21215 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 220-64-8391 | | 16c. INFORMANT Mr. Woodrow E. Brown | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 12:43 P.M. 9-10-87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) residence | | 21f. LOCATION CITY OR TOWN COUNTY STATE 2237 Brookfield Avenue Baltimore, Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | TITLE (SPECIFY) Assistant | | | DATE SIGNED 9-10-87 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9-14-87 | | 23c. NAME OF CEMETERY OR CREMATORY Int. Olivet Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balt. Md | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | | ADDRESS 2222 W. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandora |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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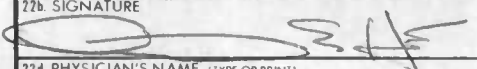
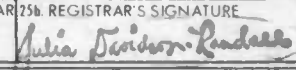
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|--|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE BROWN LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 11 87 | | 2b. HOUR 1:38 PM | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 21 8 76 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST E. BEN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA (GLOVER) Howard | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 212-36-0900 | | 17. INFORMANT ADDRESS Mary Brown (chart information) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia and Disseminated Intravascular Coagulation.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Infected Hip Prosthesis, Multiple Myeloma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 wks 4 yrs | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>September 11, 1987</u> , that (II) I saw the deceased alive on <u>September 11, 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death. | | | | | | |
| 22b. SIGNATURE  | | DEGREE MD | | 22c. DATE SIGNED 9-11-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David E. Hart | | 22e. ADDRESS University of Maryland Hospital Balto, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY Md Nat Memorial Park | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue | | 23d. LOCATION CITY OR TOWN Laurel | | 23e. COUNTY Md | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 16 1987 | | 25b. REGISTRAR'S SIGNATURE  | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon 4. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

BP

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067991 OCT-3-87

STATE OF MARYLAND 87 25488
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MOLLIE Savannah BROWN | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 12 87 | | 2b. HOUR 4:45 a.m. |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR July 20th, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Calto. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar Goods | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Savannah Moore | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 219-22-6485 | | 17. INFORMANT ADDRESS Jean A. Goods 2814 Carver Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) URINARY TRACT INFECTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ACUTE RENAL FAILURE, CIRRHOSIS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death. | | | | | |
| 22b. SIGNATURE <i>Shirley A. [Signature]</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas C. AM, MD | | 22e. ADDRESS CHURCH HOSPITAL 1000 CHURCHWAY BALTIMORE, MD. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/18/87 | 23c. NAME OF CEMETERY OR CREMATORY Westport Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Westport, Baltimore Md. | | |
| 24. FUNERAL SERVICE ONLY CHAS. A. [Signature] FUNERAL SERV. | | DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 05 1987 | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders' Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

06700 122-733-708

066599 SEP 24 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders' pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|-------------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | 2b. HOUR M | |
| Robert H Brown | | | | | 9/19/87 | | | | | | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 5 31 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Steel | | | |
| 13a. STATE Md. | | 13b. CITY OR TOWN Balto. | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 207 Walnut Ave. 21222 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Brown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WW11 | | 17. INFORMANT ADDRESS 21222 Mrs. Ola Mae Brown 207 Walnut Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary atherosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>15 minutes</u> <u>10 yrs.</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>generalized atherosclerosis</u> <u>Hypertension</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>87</u> , to <u>Sept 19</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Sept 1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Stanley D. Madison</u> | | | | DEGREE MD | | | | 22c. DATE SIGNED 9/22/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley D. Madison, M.D. | | | | 22e. ADDRESS 836 Park Avenue Balto, Md 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Vet. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons 1701 Laurens St. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1987 | | | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Dinkson-Rodgers</u> | | | | | | | |

BP

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SEP 23 1987

065278 SEP 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25490
20. DATE OF DEATH MONTH DAY YEAR 9 4 87 21. HOUR 1:15 AM

| | | | | | |
|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie Ellen Alston Brown | | 20. DATE OF DEATH MONTH DAY YEAR 9 4 87 | | 21. HOUR 1:15 AM | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 1 20 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2004 East 31st Street | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY N/A |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Harris | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Bullock | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16b. SOCIAL SECURITY NO. 217-24-6626 | | 17. INFORMANT ADDRESS James Alston 2004 E. 31st Street | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) renal failure - chronic | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF - (b) hypertensive cardiomyopathy | | 3y |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) hypertension | | many years |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

dementia; seizure disorder

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 11:00 19 85 to 9:14 19 87, that (1) (we) lost saw the deceased alive on 9/12/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Paul Gertler | | DEGREE MD | 22c. DATE SIGNED 9/14/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Gertler | | 22e. ADDRESS 3900 N. Charles St. Suite 104 Balto, Md 21218 | |

| | | | |
|---|-------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 9/11/87 | 23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CHURCH CEM. | 23d. LOCATION CITY OR TOWN COUNTY STATE HALIFAX CO., NC |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

062518 SEP 17 85



REBIB NOTOD 2902

WINTERFIELD

SEP 08 1985

Item #8, G-634, by M.L. of Wf. STATE OF MARYLAND
& F.H., 12/3/87, Gbj.
FOR
STATE
REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilson P. Brown | | | 2a. DATE OF DEATH MONTH DAY YEAR September 17, 1987 | | 2b. HOUR 9:40 AM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 07 - 28 - 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore, MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Veterans Administration Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2501 Violet Ave #1107, 21215 |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Brown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lou Cohen | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 215-05-0785 | | 17. INFORMANT ADDRESS Wilson C. Brown 3674 Forrest Hill | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis | | | | | 3 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia | | | | | 7 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure, Aortic Valve Disease, Diabetes | | | | | |
| 19a. DATE OF OPERATION 9/4/87 - 9/10/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GI Bleeding / Anastomotic Leak | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from September 4, 1987, to September 17, 1987, that (I) (we) last saw the deceased alive on 9/17/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Jeffrey A. Drebin | | DEGREE M.D. | | 22c. DATE SIGNED 9-17-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey A. Drebin | | 22e. ADDRESS Dept. of Surgery, Johns Hopkins Hospital, Baltimore 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/22/87 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1987 | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This is to certify that the death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. These remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)

067027 SEP 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25492

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--------------------------------------|--|--|--|---------------------|--|-------|--|------|--|----------|--|
| DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| MARTHA BROZOWSKI | | | | | | | | 9/25/87 | | | | | | | | 2:40P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| Female | | white | | 2 14 1922 | | 65 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| BALT MD | | USA | | | | BALT. CITY MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| BALTO. | | ST AGNES HOSP. | | HOMEMAKER | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. COUNTY | | 13d. CITY OR TOWN | | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13f. STREET ADDRESS | | | | | | | |
| MD | | BALT | | BALTO | | | | | | 1431 LANGFORD RD | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| JULIUS | | MARTHA | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 218-14-4748 | | LILLIAN BROZOWSKI | | LANGFORD RD | | | | | | | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Sepsis</u> | | 24 hrs | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) <u>Perforation of small intestine</u> | | 36-48 hrs | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) <u>INCARCERATED VENTRAL HERNIA</u> | | 48-72 hrs. | |

| | | | |
|--|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 9/24/87 | | infarcted small bowel | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | |
| | | HOUR A.M. MONTH DAY YEAR | |
| | | P.M. 19 | |
| 21d. INJURY OCCURRED | | 21e. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | STREET | |
| | | CITY OR TOWN | |
| | | COUNTY | |
| | | STATE | |
| 22a. I certify that (he) (this hospital) attended the deceased from <u>Sept. 23</u> , 19 <u>87</u> , to <u>Sept. 25</u> , 19 <u>87</u> , that (he) (we) lost saw the deceased alive on <u>Sept. 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | |
| Bert F. Morton | | M.D. | |
| 22c. DATE SIGNED | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 9/26/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| BERT F. MORTON | | St. Agnes Hospital | |

| | | | | | | | |
|---|--|-------------------------------|--|------------------------------------|--|---------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | 9/29/87 | | HOLY ROSARY | | BALTO MD | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME | | ADDRESS | | | | | |
| EDWARD J. WEBER F.H. | | 5311 | | SEP 28 1987 | | John Dandrea | |
| EDMONDSON AVE | | | | | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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066917 SEP 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25493

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | FIRST MIDDLE LAST J DA C BRUNNER | | MONTH DAY YEAR 9-21-87 | | 10 ⁰⁰ P.M. | |
| 3. SEX FEMALE | | 4. RACE Caucasian | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| | | | | MONTH DAY YEAR 6-19-1905 | | 82 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ron Secours Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker | | 12b. KIND OF BUSINESS OR INDUSTRY In Green Factory | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John C PETERBOY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Smith | | 13e. STREET ADDRESS / ZIP CODE 600 S. Monroe ST 21223 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | |
| NO | | 218-18-6199 | | | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer Squamous | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Chronic Obstructive Disease | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Provisional Atrial Fibrillation | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-22-87 to 9-21-87, that (I) (we) last saw the deceased alive on 9-21-87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | |
| 22b. SIGNATURE Daniel Wenberg | | | | DEGREE MD | | 22c. DATE SIGNED 9-21-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL WENBERG | | | | 22e. ADDRESS 3001 S. Hanover ST. | | | |

| | | | | | | | |
|--|--|------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (BY LAW) Burial | | 23b. DATE 9-25-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie G. H. Co. Md. | |
| 24. FUNERAL DIRECTOR Balt. Md. 21223 Therese Brown & Son, Inc. 901 Helms Dr. | | | | 25a. DATE RECEIVED BY REGISTRAR SEP 25 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

000015 23033

06480 SEP 25 87



COLLIER

WILLIAM



067176 SEP 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and dispose of pages 1 and 2. Page 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| DECEASED NAME (TYPE OR PRINT) SEVERN W. BUNDICK | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 28 87 | | | 2b. HOUR 10 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 15 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALT. GEN. HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY Provident Bank | |
| 13a. STATE MD | | 13b. COUNTY BALT. | | 13c. CITY OR TOWN BALT. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Balto. Md. 1649 CONINGTON ST. 21230 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SEVERN S. BUNDICK | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary B. Taylor | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-1467 | | 17. INFORMANT ADDRESS Mrs. Mary L. Bundick, Same as above | | | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Melanotic Wng CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) Elebsiella pneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructed pulmonary Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/16 1987 to 7/28 1987 , that (I) (we) lost saw the deceased alive on 9/28/87 , 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael Karzik | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KARZIK | | 22e. ADDRESS 3001 S. HANOVER ST. BALT. MD | | | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/1/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1987 | | 25b. REGISTRAR'S SIGNATURE James Davidson-Rodgers | |

067170 SEP 30 05

1. 067170 SEP 30 05

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18. 067170 SEP 30 05

066355 SEP 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25490

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARRY G BURGESS | | 2a. DATE OF DEATH MONTH DAY YEAR 9/17/87 | | 2b. HOUR 1803 P.M. | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 20, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Veteran Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Timonium | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Burgess | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Dodd | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 218124136 | | 17. INFORMANT ADDRESS Debra J. Burgess 5020 Old Court Road 21133 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UNKNOWN</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Sept. 12</u> 19 <u>87</u> , to <u>Sept. 17</u> 19 <u>87</u> , that (I) <u>xx</u> saw the deceased alive on above, (I) <u>xx</u> (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| 22b. SIGNATURE <u>Donald L. Kimpel MD</u> | | | | 22c. DATE SIGNED 9/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD L. KIMPEL MD | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9-21-87 | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222 | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1987 | 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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RECEIVED

SEP 25 1961

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

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Items 136.
9-29-87 A.L.
per phone

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25497

REG. NO

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CEPHUS CIPRIAN BURKE | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 18 87 | | 2b. HOUR 8 ⁴⁰ P M |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 9 9 09 | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) JAMAICA | 7b. CITIZEN OF WHAT COUNTRY? BALTIMORE | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SONNY BURKE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS CHART | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-30, 1987, to 9-18, 1987, that (we) lost saw the deceased alive on 9-18, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE MD | | 22c. DATE SIGNED 9-19-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY M. WEISMAN | | 22e. ADDRESS 3640 POTOSI AVE BALDWIN 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 9-23-87 | 23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMT. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME E.L. PHILLIPS | | ADDRESS 1721 N. MONROE ST. | | 25a. DATE RECD. BY REGISTRAR SEP 22 1987 | 25b. REGISTRAR'S SIGNATURE [Signature] |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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065872 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|--|--|-------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE Eve BURMEISTER | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 11 87 | | 2b. HOUR 7:00^a | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR December 19, 1905 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS MONTHS DAYS MIN. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Edgemere | | |
| 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12c. KIND OF BUSINESS OR INDUSTRY Own Home | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Graham | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Gephardt | | 13e. STREET ADDRESS / ZIP CODE 7830 Denton Ave. 21219 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 214-54-4713 | | 17. INFORMANT ADDRESS George E. Allen 801 Scott Circle 21061 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CIGARETTE SMOKING APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes Mellitus; Biventricular Failure | | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED " " | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 9 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 9/9 87 to 9/10 87 | | |
| 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 100 N. Broadway, Baltimore, MD 21231 | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 9/9 87 to 9/10 87 , that (1) we last saw the deceased alive on 9/10 87 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above (1) we did not view the body after death. | | | | | | |
| 22b. SIGNATURE Kenneth D. Byerly MD | | | | 22c. DATE SIGNED 9-10-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth D. Byerly, M.D. | | | | 22e. ADDRESS 100 N. Broadway, Baltimore, MD 21231 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-13-87 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 23e. DATE REC'D. BY REGISTRAR SEP 15 1987 | | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk | | 25. REGISTRAR'S SIGNATURE Julia Bender-Kendall | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the folder with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

002855 SEP 19 81

CLARK, W. L. JR.

CLARK, W. L. JR.
CLARK, W. L. JR.
CLARK, W. L. JR.

002855

002855 SEP 19 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

John

Butchko

2a. DATE OF DEATH MONTH DAY YEAR
9 5 872b. HOUR MIN
21:04 M

3. SEX

M

4. RACE

W

5. DATE OF BIRTH

MONTH DAY YEAR
1 27 08

6. AGE (IN YEARS LAST BIRTHDAY)

79

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Key Hospital

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Operator

12b. KIND OF BUSINESS OR INDUSTRY

Standard Oil Co

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

1817 Walnut Avenue 21222

14. FATHER'S NAME

Joseph

MIDDLE

LAST

Butchko

15. MOTHER'S MAIDEN NAME

?

MIDDLE

LAST

Mattoch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

no

16b. SOCIAL SECURITY NO.

174 01 2830

17. INFORMANT

ADDRESS

Mrs Anna Butchko 1817 Walnut Ave. Balto, Md 22

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0

Endocarditis

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Clifford S. Mitchell

22e. ADDRESS

Francis Scott Key Med. Ctr.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

9/9/87

23c. NAME OF CEMETERY OR CREMATORY

Sacred Heart

23d. LOCATION
CITY OR TOWN

Baltimore

COUNTY

STATE

Md

24. FUNERAL DIRECTOR

Walter Dabrowski 1005 Dundalk Avenue

25a. DATE REC'D BY REGISTRAR

SEP 9 1987

25b. REGISTRAR'S SIGNATURE

Julia Dunder-Rodman

082109 SEP 10 07

Maryland

USA

Baltimore

Key Hospital

Operator

Standard Oil Co

Maryland

Baltimore

x

1817 Walnut Avenue 21222

Joseph

Butchko

?

Matcoch

no

174 01 2830

Mrs Anna Butchko

1817 Walnut Ave. Balto, Md 21

Serial

7/9/57

Secretariat

Baltimore

Alfred Dabrowski 1005 Dundalk Avenue

65097 SEP 10 87

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25500

| | | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Elmer S Butter</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>SEPT 1, 1987</u> | | | 2b. HOUR M <u>AM</u> | | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>Black</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>11 29 31</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>55</u> YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore Md</u> | | 9. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE</u> MD. | | | | |
| 12. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>617 E 41st St</u> | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>UNEMPLOYED</u> | | 15. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MARYLAND</u> | | | 13b. COUNTY <u>BALTIM.</u> | | 13c. CITY OR TOWN <u>BALTIMORE</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <u>617 E 41st St. 21218</u> | |
| 17. FATHER'S NAME FIRST MIDDLE LAST <u>Joseph Mack Butter</u> | | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Gladys Johnson</u> | | | 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>YES</u> | | | | |
| 20. SOCIAL SECURITY NO. <u>212-26-9138</u> | | | 21. INFORMANT <u>Mr. Donald M. Butler</u> | | | 22. ADDRESS <u>3616 Fairview Ave</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Insulin dependent diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic alcoholism</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>at least 4 yrs.</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hypertension, peripheral neuropathy, gout, chronic pancreatitis</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>-</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 16</u> , 19 <u>87</u> , to <u>July 31</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>July 31</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert Tao-Ping Chow</u> | | | | | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/3/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT TAO-PING CHOW</u> | | | | | | 22e. ADDRESS <u>WYMAN PARK HEALTH CENTER, 3100 WYMAN PARK DR</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>9-5-87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Garrison Forest Va. Cem</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balt. Co. Md</u> | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <u>Joseph L. Russ 2222 W. North Ave</u> | | | | | | | | | | |
| 25. DATE REC'D. BY REGISTRAR <u>SEP 09 1987</u> | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B above, any injury, or other traumatic event, the medical examiner must be notified at once.

SEP 10 01

SEP 09 1901

066988 SEP 29 1987

FOR
STATE
GISTRAR

Item 2a Film G332 10-27-87 STATE OF MARYLAND
per funeral home SB DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2550

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Butler | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 24 87 | | | 2b. HOUR 11:00a. | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 09 28 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Century Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Oper. | | 12b. KIND OF BUSINESS OR INDUSTRY Gen Star | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1134 E. 20th STREET 21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS BUTLER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes | | | |
| 16b. SOCIAL SECURITY NO. 218-01-5625 | | | 17. INFORMANT ADDRESS Lee Brown, 1134 E. 20th St., 21218 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-1-86 to 9-24-87 that (I) (we) last saw the deceased alive on 9-24-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | | DEGREE | | 22c. DATE SIGNED 9-25-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. NAIR, MD | | | | | | 22e. ADDRESS 5010 YORK Road BALTIMORE MD 21212 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9/29/87 | | 23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN, MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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066379 SEP 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25504

REG. NO.

| | | | | | |
|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) TIMOTHY BYERS | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 17 87 | | 2b. HOUR 12:55 PM |
| 3. SEX MALE | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR 04 04 50 | | 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Balto | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Seton Hill Manor | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder | | 12b. KIND OF BUSINESS OR INDUSTRY Construction |
| 13a. STATE Maryland | | 13b. COUNTY Balto | 13c. CITY OR TOWN Balto | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William C. Buyers | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Davis | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16b. SOCIAL SECURITY NO. 212-56-5381 | | 17. INFORMANT Deton Hill Manor N.H. | | ADDRESS 501 W. Franklin St. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Opportunistic Infection (Candida) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) AIDS DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Multiple Brain Lesions (No biopsy done) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-17-87 to 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Jaime Punzalan | | DEGREE MD | | 22c. DATE SIGNED 9/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAIME PUNZALAN | | 22e. ADDRESS 5214 Haywood Rd. Balt. Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-19-87 | 23c. NAME OF CEMETERY OR CREMATORY MT Zion | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balt Co. MD |
| 24. FUNERAL DIRECTOR NAME ADDRESS Joe F. Quinn 1712 W. North | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper from page 1, and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

060310 SEP 25 81



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CHIEF

065011 SEP-987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH25503
REG. NO.

| | | | | | |
|---|--------------------------------------|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) JENNIE MAE BYRD | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-02-87 | | 2b. HOUR 9 AM |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 02 27 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY -0-0-0-0 |
| 13a. STATE Md | | 13b. COUNTY None | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie Byers | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizebeth Foster | | 13e. STREET ADDRESS / ZIP CODE 2713 Uhler Ave. 21215 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 0-0-0-0-0 | | 16b. SOCIAL SECURITY NO. 240-30-6166 | | 17. INFORMANT ADDRESS Dorothy Borden 2713 Uhler Ave. 21215 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory arrest.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Metastatic gastric Ca.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 9a. DATE OF OPERATION 7/87 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Stomach Ca. | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 09/01, 1987, to 09/02, 1987, that (I) (we) last saw the deceased alive on 09/02, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Chossan Araysi | | DEGREE M.D. | 22c. DATE SIGNED 09/02/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARAYSI | | 22e. ADDRESS Bon Secours Hospital | |

| | | | |
|---|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (S, F, R) Burial | 23b. DATE 9/5/87 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md |
| 24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 08 1987 Julia Borden | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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SEP 8 1961

065522 SEP 15 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARGARET CECILIA Cahill | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/9/87 | | 2b. HOUR 0415 M | | | | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 9 17 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired-Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Secretary | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Bal | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John J. Cahill | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Ellen Collins | | | | 16. ADDRESS Randalstown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216093620A | | 17. INFORMANT Mrs. Walter Reiter | | | | ADDRESS 6 Burr Oak Ct. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) sepsis DUE TO, OR AS A CONSEQUENCE OF (c) CVA | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE K. Rikabi | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Khaled Rikabi | | | | 22e. ADDRESS 900 CATON Avenue, St. Agnes Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md. | | | |
| 24. FUNERAL DIRECTOR 336 Edmondson Ave Sterling Ashton Funeral Estate, PA | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The physician's name and address should be typed on page 3 and the certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

082255 SEP 12 81

RECEIVED
SEP 12 1981
U.S. DEPARTMENT OF
ENERGY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

065343

SEP 09 1987
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25305

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sylvetta Cain</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>09 06 87</i> | | | | 2b. HOUR <i>1:20 P.M.</i> | |
| 3. SEX <i>FEMALE</i> | | 4. RACE <i>BLACK</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>6 6 1895</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i> | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MERCY HOSPITAL</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>N/A</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>BALTIMORE</i> 13c. CITY OR TOWN <i>BALTIMORE</i> | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>1004 WEBB COURT 21202</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-32-1525A</i> | | 17. INFORMANT ADDRESS <i>BERTHA REYNOLDS 201 BROADWAY APT. 9F</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Keith Friedel</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <i>09/09/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Keith Friedel</i> | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>9/9/87</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>MOUNT ZION CEMETERY</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>LANSDOWNE MD</i> | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Carroll Campbell March F.H. 928 E. North Ave</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 10 1987</i> | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

BP

002313 SEP 14 87

SEP 10 1987

066240 SEP 18 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25506

REG. NO.

FOR
1 - STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
Benjamin F. Caldwell.

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
9.16.87 4.20 PM

1 SEX

M

4 RACE

Black

5 DATE OF BIRTH

MONTH DAY YEAR
12 25 1918

6 AGE (IN YEARS LAST BIRTHDAY)

UNDER 1 YEAR # UNDER 24 HRS
MONTHS DAYS HOURS MIN.

68

7a BIRTHPLACE (STATE OR FOREIGN
COUNTRY)

Ga

7b CITIZEN OF WHAT COUNTRY?

USA

MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Baltimore city

MD.

10 CITY OR TOWN OF DEATH

Balt.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Liberty Medical Center

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired

12b KIND OF BUSINESS OR
INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Md

13b COUNTY

Baltimore

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

2555 Arunah Ave 21216

14 FATHER'S NAME

Walter

MIDDLE

Caldwell

15. MOTHER'S MAIDEN NAME

Sarah

MIDDLE

Simmons

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO

412-28-4882

17 INFORMANT

Mildred Gross

ADDRESS

2555 Arunah Avenue

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary failure.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

-Sept 8.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a DATE OF OPERATION

7/12/87

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

Upper G.I. bleeding

20a AUTOPSY?

YES ☐ NO ☒20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 7/12, 1987, to 9/16, 1987, that (I) (we) lost
saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

[Signature]

DEGREE

MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

[Signature] I smoke

22e ADDRESS

Liberty Med. Center

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

9/19/87

23c NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

23d LOCATION

Arbutus

COUNTY

STATE

Md

24 FUNERAL DIRECTOR

Wm. C. March F/H West 4300 Wabash Avenue

25a DATE REC'D. BY REGISTRAR

SEP 18 1987

25b REGISTRAR'S SIGNATURE

[Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

080510 SEP 19 67



67010 SEP 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25507

| | | | |
|---|---|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | |
| FAY E. CAMPANIDES | | MONTH DAY YEAR 9 21 19 87 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) |
| Female | White | 7 15 43 | 44 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Baltimore, Md. | USA | | Baltimore City MD |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | University Hospital (STU) | Manicurist | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Md. | Carroll | Manchester | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| Alfred E. Shanks | Dora Keenan | no | |
| 17a. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | |
| 215-44-1661 | Mrs. Dora Shanks | Manchester, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 3:50 P.M. 9-21-1987 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/fixed object impact. | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | 21f. LOCATION STREET Hanover Pike, 500 ft. north | CITY OR TOWN Baltimore, MD |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | TITLE (SPECIFY) Deputy Chief | DATE SIGNED | |
| Ann M. Dixon, M.D. | M.D. | 9-22-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | ADDRESS | 111 Penn St., Balto., MD 21201 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 9-24-87 | Mt. Olivet Cemetery | Hanover York Pa. |
| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Eline Funeral Home | Hampstead, Md. | SEP 28 1987 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

01050 219 33 01

REC'D COTTON 202

DATE 11/11/10



065768 SEP 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25500

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH MAY CAMPBELL | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 14 87 | | 2b. HOUR 1330 M |
| 3. SEX Female | 4. RACE Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR 04 03 94 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY — |
| 13a. STATE MD | | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN REISTERSTOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN DESSA ARNOLD | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE DESSA METZ | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 516-87-5009 | | 17. INFORMANT ADDRESS 337 BRYANSTONE RD REISTERSTOWN MD 21136 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE CARDIAC FAILURE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 da |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PROBABLE MI | | | | | 10 da |
| DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction | | | | | PULMONARY |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION 8/27/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED DISLOCATED @ Hip prosthesis | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/27/87 to 9/14 19 87 , that (I) (we) last saw the deceased alive on 9/14 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Roxanne S. Donovan | | | | 22c. DATE SIGNED 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROXANNE S. DONOVAN | | | | 22e. ADDRESS Sinai Hosp. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, BALTIMORE, MD | | 23e. DATE REC'D BY REGISTRAR SEP 15 1987 | | | |
| 24. FUNERAL DIRECTOR NAME Edmund H. Hightower | | ADDRESS OWINGS MILLS, MD | | 25. REGISTRAR'S SIGNATURE Lia E. Givens-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be furnished for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked as illegal, any injury, or other traumatic event, the medical examiner must be notified at once.

BP

0 0 5 2 3 1

067523 OCT

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

Item 11-10-2-8702
130 - Phone

1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
John M Campbell

2a. DATE OF DEATH MONTH DAY YEAR
Sept 20, 87 2b. HOUR
625A

3. SEX *M* 4. RACE *White* 5. DATE OF BIRTH MONTH DAY YEAR
1 1 1919 6. AGE (IN YEARS LAST BIRTHDAY) *68*

7a. BIRTHPLACE (CITY OR FOREIGN COUNTRY) *Unknown* 7b. CITIZEN OF WHAT COUNTRY? *Unknown* 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Balt City MD

10. CITY OR TOWN OF DEATH *Unknown* 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lincoln Convalescent Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY

13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. CITY 13c. COUNTY 13d. CITY OR TOWN 13e. INSIDE CITY LIMITS? *YES* ☐ *NO* ☐ 13f. STREET ADDRESS / ZIP CODE
12176 Layette Rd. 21223

14. FATHER'S NAME FIRST MIDDLE LAST *Unknown* 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST *Unknown*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. *214-05-2898* 17. INFORMANT ADDRESS
Lincoln Conv. Center

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Cardio-Respiratory Collapse*
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) *Congestive Heart Failure*
DUE TO, OR AS A CONSEQUENCE OF
(c) *Old Cerebro-Vascular Accident*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *None*

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? *YES* ☐ *NO* ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? *YES* ☐ *NO* ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
9-19-87 P.M. *19* 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
8-26-87 *9-20-87*

22. I certify that (I) (this hospital) attended the deceased from *9-19-87* to *9-20-87* that (I) (we) last saw the deceased alive on *9-19-87* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23a. SIGNATURE *A-I. Baykaler* DEGREE *MD* 23b. DATE SIGNED *9-20-87*

23c. PHYSICIAN'S NAME (TYPE OR PRINT) *A-I. BAYKALER* 23d. ADDRESS *831 Poplar Grove St. Balt.*

23e. BURIAL, CREMATION, REMOVAL (DATE) 23f. DATE *9/21/87* 23g. NAME OF CEMETERY OR CREMATORY *EASTVIEW Cem.* 23h. LOCATION CITY OR TOWN COUNTY STATE
BALTO. MD.

24. FUNERAL DIRECTOR NAME ADDRESS
BETH'S FUNERAL HOME 1129 N. CAROLINE 25a. DATE REC'D. BY REGISTRAR *SEP 21 1987* 25b. REGISTRAR'S SIGNATURE *Julie Davidson-Randall*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please advise the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

083253 OCT-58



CHIEF IN CHARGE

SEP 21 1958

065675 SEP

Item, 21c., G-634, by Med. Exam. 12/18/87 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25510

FOR
DATE
GISTRAR

Gbj.

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|---|--|------------------------------------|--|--|----------------|------------------|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| SIMONE | | | CURTIS | | | CAMPBELL | | | 9-10-87 | | | 12:10 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | |
| MALE | | B | | 4/14/68 | | 19 YRS. | | | | | | 9-10-87 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| BALTO., MD. | | | | U.S.A. | | | | | | | | Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | University Hospital STU | | | | N/A | | | | N/A | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| MD | | | | | | | | BALTO. | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 13e. STREET ADDRESS | | | | 21216 | | | |
| SIMON CAMPBELL | | | | ETHEL MAE CAMPBELL | | | | 2708 N. ROSEDALE ST. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| NO | | | | N/A | | | | 212-16-3201 | | | | ETHEL & SIMON CAMPBELL 2708 ROSEDALE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: Head injuries with complications | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| | | | | 1:19AM 8-26-87 | | | | driver of an auto/ Auto(s) impact subject ejected | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | hwy. | | | | Rt. 29 near Gorman Rd. Columbia, Maryland | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE | | | | SIGNED | | | |
| Margarita A. Korell, M.D. | | | | Assistant | | | | 9-10-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| BURIAL | | | | 9/16/87 | | GARRISON FOREST | | | | OWINGS MILL, MD. | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| LEROY O. DYETT 4600 LIBERTY HEIGHTS | | | | SEP 15 1987 | | | | Julia Davidson-Randall | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

002012 SEP 19 81

18

RECEIVED

NOTICE

2000



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 5 5 1 1

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|---------|--|------------------|--|---------------------------------|--|-----------------|--|------------------|--|--|
| DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Anna Spencer Canitz | | | | | 09 28 87 | | | | | 0335AM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | White | | 7-1-02 | | 85 | | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore City | | The Union Memorial Hospital | | | | Clerk | | Banking | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS, / ZIP CODE | | | |
| Maryland | | Baltimore | | White Marsh | | | | 5622 Carrington Dr. 21162 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| John D. Spencer | | Adelaide C. | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | 216-58-0171 | | Rose Canitz 1109 Chester Road 21220 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: | | | | | | | | | | | |
| (b) <u>Sepsis</u> | | | | | | | | | | ~1 week | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Esophageal rupture</u> | | | | | | | | | | ~1 month | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 8/24 | | Esophageal rupture | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I. OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/24 19 87 to 9/28 19 87, that (I) (we) last saw the deceased alive on 9/28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | |
| 22b. SIGNATURE <u>Steven J. Lawrence MD</u> DEGREE | | | | | | | | | | 9/28/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | |
| Steven J. Lawrence MD | | | | | | | | | | Union Memorial Hospital Balt. MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 10-1-87 | | Oaklawn | | Baltimore Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Mitchell-Wiedefeld Home 6500 York Road 21212 | | | | | | SEP 30 1987 | | <u>Steven J. Lawrence</u> | | | |

MEDICAL CERTIFICATION

9/28/87

MD

BP

DHMH - 16 60M 7/84 (VRS 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 272 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified for investigation.)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

067200 OCT-1-67

SECRET

7-1-67

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067874 OCT - 87

FOR Items #14, 15 & 632
STATE REGISTRAR 10/30/87 CWSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|------------------------|---|---|---|--------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST <i>Sylvia</i> | | MIDDLE | | LAST <i>Canty</i> | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <input checked="" type="checkbox"/> 9 29 19 87 | | 2b. HOUR M 7:45 P | |
| 3 SEX <i>Female</i> | 4 RACE <i>Black</i> | 5 DATE OF BIRTH MONTH DAY YEAR <i>6 - 2 - 34</i> | 6 AGE (IN YEARS) LAST BIRTHDAY YRS. <i>53</i> | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>9 29 19 87</i> | | 7d. HOUR M | | 7e. MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>NEW YORK</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Brooklyn</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>1625 Fulton Ave.</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John Hill</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dorothy Forest</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. <i>215-32-0334</i> | | 17. INFORMANT <i>Chart</i> | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18. <i>Chronic obstructive pulmonary disease & Diabetes mellitus</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <i>Natural causes</i> <input checked="" type="checkbox"/> <i>Accident</i> <input type="checkbox"/> <i>Suicide</i> <input type="checkbox"/> <i>Homicide</i> <input type="checkbox"/> <i>Undetermined manner</i> <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i> | | TITLE (SPECIFY) <i>Assistant</i> MEDICAL EXAMINER | | | | | | DATE SIGNED <i>9/30/87</i> | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS <i>Mario F. Golle, Jr., M.D. 111 Penn St. Balto., MD.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i> | | 23b. DATE <i>10/5/87</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>WESTVIEW M. PARK</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>E.L. Phillips</i> | | ADDRESS <i>172 N. Monmouth St.</i> | | 25a. DATE FILED BY REGISTRAR <i>OCT 7 1987</i> | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

066303 SEP 18 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

Gilbert

H.

Carroll

2a. DATE OF DEATH

MONTH

DAY

YEAR

09 16 87

2b. HOUR

10:40 AM

3. SEX

male

4. RACE

Black

5. DATE OF BIRTH

MONTH

DAY

YEAR

07 30 35

6. AGE (IN YEARS LAST BIRTHDAY)

52

7. IF UNDER 1 YEAR

MONTHS

DAYS

8. IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Baltimore, Md

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Liberty Medical center

12a. USUAL OCCUPATION

Unemployed

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13. STREET ADDRESS / ZIP CODE

3506 Forest Park Ave

21216

14. FATHER'S NAME

Francis W.

MIDDLE

Carroll

LAST

Carroll

15. MOTHER'S MAIDEN NAME

Pearl

MIDDLE

Smith

LAST

Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

YES, NO OR UNKNOWN

Yes

16b. SOCIAL SECURITY NO.

1954-1958 212-33-9385

17. INFORMANT

Mrs Pearl Witherspoon

ADDRESS

3915 Liberty Heights Ave

21215

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Resp. arrest 2° Lung CA with metastases

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last

saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

T. Chikereh, MD

DEGREE

MD

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

9-16-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

T. Chikereh, MD

22e. ADDRESS

Liberty medical center

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

9-21-87

23c. NAME OF CEMETERY OR CREMATORY

Garrison Forest Bur. Cen

23d. LOCATION

Baltimore, Co. MD

COUNTY

STATE

24. FUNERAL DIRECTOR

Joseph L. Russ

ADDRESS

2222 W. North Ave

25a. DATE REC'D BY REGISTRAR

SEP 18 1987

25b. REGISTRAR'S SIGNATURE

J. Anderson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript and the necessary removal carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 should be marked, the medical examiner must be notified of this.

020303 SEP 10 01

WILLIAM L. B. B.

SEP 10 1961

SEP 10 1961

66230 SEP 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 25514

| | | | | | | | |
|---|---|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH L CARROLL JR. | | | 2. DATE OF DEATH MONTH DAY YEAR 9/16/87 | | | 2b. HOUR 2:14 PM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12 29 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLAIM EXAMINER | | 12b. KIND OF BUSINESS OR INDUSTRY SOCIAL SEC. ADM. |
| 13a. STATE MD. | | 13b. COUNTY - | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4319 SPRINGWOOD AVE. 21206 | | |

| | | | |
|--|--|--|--|
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH L. CARROLL, SR. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DOLAN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | 16b. SOCIAL SECURITY NO. W.W. II 360-14-7095 | 17. INFORMANT ADDRESS Mrs. Johanna Carroll - 4422 Forge Rd. 21128 | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IRREVERSIBLE BRAIN INJURY | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 DAYS |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral infarction | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

| | | | |
|--|---|--|--|
| 19a. DATE OF OPERATION 9/2/87 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Transient ischemic Attacks | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from **8/31/87**, 19____, to **9/16/87**, 19____, that (I) (we) last saw the deceased alive on **9/16/87**, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---------------------|---|------------------------------------|
| 22b. SIGNATURE [Signature] | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 9/16/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEREMY WEINER | | 22e. ADDRESS 3100 Wyman Park Drive Dept of SURGERY Balto, MD 21211 | |

| | | | |
|--|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 9-19-1987 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. |
|--|-------------------------------|--|---|

| | | | |
|--|--------------------------------------|---|--|
| 24. FUNERAL DIRECTOR NAME [Signature] | ADDRESS - 7527 Harford Rd. | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | 25b. REGISTRAR'S SIGNATURE [Signature] |
|--|--------------------------------------|---|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

I have a copy of the
 report of the
 committee on the
 subject of the
 investigation of the
 activities of the
 group known as the
 "Black Liberation Army"
 which was conducted by
 the FBI in 1968.
 The report is dated
 10/1/68 and is
 classified "Secret".
 I am enclosing a
 copy of this report
 for your information.
 Very truly yours,
 J. Edgar Hoover

The report is a
 detailed account of
 the activities of the
 group known as the
 "Black Liberation Army"
 which was conducted by
 the FBI in 1968.
 The report is dated
 10/1/68 and is
 classified "Secret".
 I am enclosing a
 copy of this report
 for your information.
 Very truly yours,
 J. Edgar Hoover

065483 SEP 15 '87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25515

| | | | | | | | | |
|--|---|--|---|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST | MIDDLE | LAST | MONTH | DAY | YEAR | HOUR | MIN. | SEC. |
| Helen M Carter | | | Sept 10 1987 | | | 10:10 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| Female | W | MONTH | DAY | YEAR | YRS | MONTHS | DAYS | |
| | | 5 30 03 | | | 84 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MD | USA | | | | | Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | Caton Manor Nursing Home | | | Seamstress | | | Clothing | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| MD | | | Anne Arundel | | | Linthicum | | |
| 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 537 Shipley Rd 21090 | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST | MIDDLE | LAST | FIRST | MIDDLE | LAST | | | |
| Howard Satterfield | | | Virginia Mason | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| No | | | 212-09-3783 | | | Helen Bryant, 537 Shipley Road | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> | | | | | | | | 10 min. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| (b) <u>ASCVD</u> | | | | | | | | 10 |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| <u>Metastatic Cancer - Source unknown / renal failure</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <u>9/14/87</u> to <u>9/10/87</u> the (1) (we) last saw the deceased alive on <u>9/14/87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | 22c. DATE SIGNED | |
| <u>[Signature]</u> | | | | | MD | | 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | |
| Dr. Ross | | | | | Caton Manor Nursing Home | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | 9/14/87 | | Balto. National Cem. | | Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | 21229 | | SEP 14 1987 <u>[Signature]</u> | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove card 3 and 4. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic incident, the medical examiner must be notified at once.

82183 SEP 12 84

SEP 14 1884

067596 OCT -5 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) LEVI CARVER | | | 20. DATE OF DEATH MONTH DAY YEAR 9-26-87 | | | 2b. HOUR M | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 2 17 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS CARVER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGGIE LOVE | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS CHART | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old Inf. Infarction 1966</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>1966</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a): <u>0</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>0</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-16</u> , 19 <u>1966</u> , to <u>9-26</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8-7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Thos. Swisher Jr M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9-29-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ryle Swisher Jr</u> | | | | 22e. ADDRESS <u>3455 Wilkens Ave Balt, MD 21229</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-30-87 | | 23c. NAME OF CEMETERY OR CREMATORY MD. NAT. MEM. PK | | 23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL MARYLAND | |
| 24. FUNERAL DIRECTOR NAME ADDRESS E.L. PHILLIPS 1721 N. MONROE STREET | | | | 25a. DATE REC'D. BY REGISTRAR OCT - 2 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and legibly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified once.

BP

067208 001-205

RECEIVED
OFFICE OF THE
DIRECTOR
JAN 11 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Carver, Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 23 87 | | 2b. HOUR 03:07 M | | |
| 3. SEX M | | 4. RACE B 2 | | 5. DATE OF BIRTH MONTH DAY YEAR 08 01 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE, COUNTRY OR COLONY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory | | 12b. KIND OF BUSINESS OR INDUSTRY fire | |
| 13a. STATE MD | | 13b. COUNTY — | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS CARVER SR. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGGIE CARVER | | 13e. STREET ADDRESS 151 N Monastery Av | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS PATTIE CARVER 151 N. MONESTARY AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiration Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) CHF, CVA | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18 | | | | | | | |
| 19a. DATE OF OPERATION 9-23-87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHF, CVA | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00 PM 09 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-09-87 to 9-23-87 , that (I) (we) last saw the deceased alive on 9-23-87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Jeffrey T. Haugh | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9-23-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey T. Haugh | | 22e. ADDRESS St Agnes Hosp., Balt., MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD. | |
| 24. FUNERAL DIRECTOR LEROY O. DYETT 4600 LIBERTY HEIGHTS | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Deason-Randall | |

BP

087534 293081

067542 OCT-58

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 5 3 1 8

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles E. Casey, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 30, 1987 | | 2b. HOUR 5:00PM |
| 3. SEX Male | 4. RACE Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR July 5, 1912 | | 6. AGE (IN YEARS, LAST BIRTHDAY) 75 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1129 Newcomb Way, 21205 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fork Lift Opr. | | 12b. KIND OF BUSINESS OR INDUSTRY Martin Marietta |
| 13a. STATE Maryland | 13b. COUNTY -- | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1129 Newcomb Way, 21205 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H. Casey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie B. Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -- | | 16b. SOCIAL SECURITY NO. 214-01-5948 | | 17. INFORMANT ADDRESS Julia Wright, 1131 Newcomb Way, 21205 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mitral valve Disease</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Lung Disease</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> , 19 <u> </u> to <u>present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>after 2 weeks ago</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Sheldon Gottlieb</u> | | DEGREE | | 22c. DATE SIGNED 10/1/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sheldon Gottlieb, M.D. | | 22e. ADDRESS Francis Scott Key Medical Cntr. 4940 Eastern Ave, 21224 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 10/3/87 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md. | |
| 24. FUNERAL DIRECTOR NAME 3331 Brehms Lane SCHIMUNEK FUNERAL HOME, Balto, Md. 21211 | | 25a. DATE REC'D. BY REGISTRAR OCT 2 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Wright</u> | |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

4

January 1961
1961-1-1

12/10

12/10

065660 SEP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
5-87 REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Delores M Caviness | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 11 87 | | | 2b. HOUR 1107 M | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 05 17 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Dorn | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Schaeffer | | | 13e. STREET ADDRESS / ZIP CODE 874 Carroll St. 21230 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 916-189507 | | 17. INFORMANT Address William Connors 2106 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/11</u> , 19 <u>87</u> , to <u>9/11</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE S. McCormack MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 9-11-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. McCormack MD | | | | | | 22e. ADDRESS 22 S. Greene St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IFY) | | | 23b. DATE 9/15/87 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem | | 23d. LOCATION G.M. Pritchard Highway Md. | | |
| 24. FUNERAL DIRECTOR NAME Charles L. Stevens Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | | | |
| 25b. REGISTRAR'S SIGNATURE Julia Gordon-Pauline | | | | | | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The permit is a separate companion page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

P 1 22 5

062000 SEP 12 81

SEP 14 1981

065932 SEP 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 23a, 23d G631 9-17-87 SB

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25520

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--------|--|-------------------|--|-------|---|------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| SALLIE | | | | CHALK | 9 | | 12 | 87 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | | BLACK | | MONTH DAY YEAR 6 6 19 | | 68 | | YRS MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| SC | | U.S.A. | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | 1071 CAMERON ROAD | | | | RETIRED | | DOMESTIC | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | | | |
| MD | | | | BALTO. | | | | 1071 CAMERON ROAD 21212 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST TOM CHALK | | FIRST MIDDLE LAST BELL PRICE | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| NO | | 217-22-2805 | | WILLIE OWENS 1213 RAMBLEWOOD ROAD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CARDIAC ARRHYTHMIA</u> | | | | | | | | | | <u>3 minutes</u> | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC VASCULAR DISEASE</u> | | | | | | | | | | <u>48 years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>July</u> , 19 <u>87</u> , to <u>Sep 12</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>8/24/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| | | Anthony Bleyer, MD | | | | | | 9/16/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Anthony Bleyer, MD | | Johns Hopkins Hospital, Baltimore, MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| BURIAL | | 9-17-87 | | Baltimore Cemetery | | BALTIMORE RANDALLSTOWN, COUNTY MD | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | SEP 16 1987 | | | | Julia Davidson-Parker | | | | | |

BP

002035 SEP 17 87

002035
SEP 17 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME (FOR PRINT) GERTRUDE S. CHASE | | | 2a. DATE OF DEATH MONTH 9 DAY 17 YEAR 87 | | 2b. HOUR 4:55A^M |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH 12 DAY 23 YEAR 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 | IF UNDER 1 YEAR HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | |
| 10. CITY OR TOWN OF DEATH Balto | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Balto 13c. CITY OR TOWN Turners | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2715 Delk Ct. 21222 | |
| 14. FATHER'S NAME FIRST John MIDDLE F. LAST Dorsey | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Simms LAST Simms | | 16. ADDRESS Rev. Howard Dawson - 2715 Delk Ct. 21222 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Rev. Howard Dawson - 2715 Delk Ct. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANOXIC ENCEPHALOPATHY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ACUTE MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/13/87 to 9/17/87 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13/87 to 9/17/87 that (I) (we) last saw the deceased alive on 9/17/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE A.C. Chouvalit, M.D. | | DEGREE | | 22c. DATE SIGNED 9/17/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. CHOUVALIT, M.D. | | 22e. ADDRESS NORTH CHARLES GENERAL HOSP, 28th CHARLES ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-21-87 | 23c. NAME OF CEMETERY OR CREMATORY Westview | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md. |
| 24. FUNERAL DIRECTOR NAME Jas. A. MORTON & Sons ADDRESS 1701 Laurans | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Borden-Rudolph | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 1 should be detached for use on the burial-transit permit. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, medical trauma must be noted at office.

BP

066301 SEP 19 81

Handwritten notes and a table on lined paper. The text is mostly illegible due to fading and bleed-through. A table with multiple columns and rows is visible in the lower half of the page.

066244 SEP 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST William Chesson Jr | | MONTH DAY YEAR 9 12 87 | | 4 10 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | |
| male | Black | MONTH DAY YEAR 12 16 19 | | 67 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | U.S. | | | CITY MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | LIBERTY MED. CENTER | | RETIRED | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| MARYLAND | | | BALTIMORE | 2008 Whittier Ave. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST William M. Chesson | | FIRST MIDDLE LAST MURTEL A WALLACE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES | | 212-12-0051 | | CHART | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive CVA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HTN</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/27</u> 19 <u>87</u> to <u>9/12</u> 19 <u>87</u> , that (I) (we) saw the deceased alive on <u>9/12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | 22c. DATE SIGNED <u>9/12/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| Tajudeen I. Ohiokpelu | | | | Liberty Medical Center | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 9/17/87 | | GARRISON FOREST VET. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS E. L. Phillips 1721-27 N. MONROE ST. | | SEP 18 1987 | | Julia Davidson-Rodgers | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

086254 952 442200

9

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

NELSON

William

CHESTER, Sr.

2a. DATE KNOWN OF DEATH ☒ ESTI- MATED ☐ MONTH DAY YEAR 9 28 19 87 2b. HOUR M 8:53 P

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH MONTH DAY YEAR

Sept. 24 25

6. AGE (IN YEARS LAST BIRTHDAY)

62 YRS.

IF UNDER 1 YR. MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 28 19 87 7d. HOUR 8:53 P

8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Key Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Fork Lift Operator
12b. KIND OF BUSINESS OR INDUSTRY
Crown Port & Seal

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Maryland

13b. COUNTY
Baltimore

13c. CITY OR TOWN
Dundalk

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS
2509 York Way Apt. D 21222

14. FATHER'S NAME FIRST MIDDLE LAST

William

Henry

Chester

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

Beulah

E.

Eiserman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
NO

16b. SOCIAL SECURITY NO.
212-20-5588

17. INFORMANT ADDRESS
Stella M. Chester 710 Primson Ave. 21229

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)
Deputy Chief

DATE SIGNED 9-29-87

EXAMINER'S NAME (TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
10/2/87

23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland

24. FUNERAL DIRECTOR NAME

ADDRESS

Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229

25a. DATE REC'D. BY REGISTRAR
OCT 2 1987

25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall

DHMH - 17
(VR A15 ME (1))

BP

07/84
25M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

087274 OCT-285

MADE IN U.S.A.

MADE IN U.S.A.



MADE IN U.S.A.

066747 SEP 25 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|--|---|----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THERESITA CHINN | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 22, 1987 | | 2b. HOUR MIN 8:47 A | |
| 3. SEX FFEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 1 5 19 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 68 | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 13a. STATE MD | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA HAYNIE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ST MARY SIMINARY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 22A-56 9025 | | 17. INFORMANT ADDRESS THEOLIA POLK 1543 E. 36th STREET | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RETROPERITONEAL LEOMYOSARCOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MINS 13 mos | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 19 , 19 87 , to SEPT 22 , 19 87 , that (I) (we) lost saw the deceased alive on SEPT 22 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | |
| 22b. SIGNATURE Eric B. Lieberman | | DEGREE MD | | 22c. DATE SIGNED 9-22-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC B. LIEBERMAN | | 22e. ADDRESS 600 N. WOLFE ST. BALTIMORE MD 21205 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY MT ARBURN CEMETERY | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD | | 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 24 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their place on the same papers. Pages 1 and 2 should be filed with the funeral director.

with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

BP

10 62 932 5 1 5 8 8 0

066509 SEP 23 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|---------|--|-------------------|---|------|---|------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| George FRANK Chrystie | | | | DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9-17 1987 | | | | HOUR 8:45P | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | | |
| Male | White | 9 11, 1918 | 69 YRS. | MONTHS | DAYS | HOURS | MIN. | 9-17 1987 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS | | | |
| Baltimore | | University Hospital | | | | Seaman | | Merchant Marine | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | |
| Maryland | | | | Baltimore | | Dundalk | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET ADDRESS | | | | 13f. STREET ADDRESS | | | | | | | |
| | | | | 7018 Holabird Ave./21222 | | | | | | | |
| 4. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Frank Chrystie | | | | Helen Devine | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| Yes WW II | | | | 217/09/6053 | | Earl C. Wolinski/2401 Fairway Balto., Md. | | 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head and neck injuries with complications</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 5:00PM 9-5-87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| | | | | | | Driver in auto/auto collision | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) | | 21f. LOCATION | | | | | |
| | | | | Street | | Madison and Ensor Streets, Baltimore City, Baltimore, Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| Mario F. Golle, Jr., M.D. | | | | Assistant | | | | 9-19-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| Mario F. Golle, Jr., M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Cremation | | 9/21/1987 | | Green Mount Crematory | | Baltimore, Maryland 21202 | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Walter Brooks Bradley, Inc. Balto., Md. 21222 | | | | SEP 22 1987 | | | | Julie Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

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100% COTTON FIBER

MADE IN U.S.A.

SEP 23 1960

066174 SEP 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25526

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--------|---|---|---|--|-------------------------------------|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | 2a DATE KNOWN OF DEATH | | | 2b HOUR | | |
| John Leonard City Jr. | | | DATE ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9/ 16/ 87 | | | 4:06 P M | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c DATE PRONOUNCED DEAD | | |
| Male | Cauc. | 3-28-43 | 44 yrs. | | | 9/ 16/ 87 | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | | USA | | | | Baltimore City, MD | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a USUAL OCCUPATION (TYPE OF WORK OR OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | 3400 Parklawn Ave. | | Court Commissioner | | St. Of Md. | | |
| 13a STATE | | | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | 13e STREET ADDRESS | | |
| Md. | | | | Balto. | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 21213 3400 Parklawn Avenue | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | |
| John L. City Sr. | | | | Catherine Collins | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | |
| yes | | | Vietnam | | Kathleen City same address | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| | | | HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR P.M. 9/ 16/ 87 | | self-inflicted wound. | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f LOCATION | | | |
| | | | home | | 3400 Parklawn Ave., Balto. City, Md. | | | |
| 22a I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Manner <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | | DATE SIGNED | |
| <i>Dennis F. Smyth</i> | | | Assistant | | | | 9/17/87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | |
| Dennis F. Smyth, M.D. | | | 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | |
| Burial | | 9-19-87 | | Lorraine Park | | Balto., Md. | | |
| 24 FUNERAL DIRECTOR | | | | 25a DATE REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Schmunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | | | | SEP 18 1987 | | <i>Julia Davidson-Randall</i> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

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MADE IN U.S.A.

MADE IN U.S.A.



SEP 18 1981

065868 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25527

| | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joseph J. Ciurca Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR September 13, 1987 | | | 2b. HOUR M AM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 2, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 00 00 | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3613 Bayonne Avenue | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dry Cleaner. | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Mariano Ciurca | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luigina Agro | | | 16. STREET ADDRESS / ZIP CODE 3613 Bayonne Avenue 21206 | | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 18. INFORMANT Mrs. Lucy Ann Ciurca | | 19. ADDRESS same as # 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Michael Auerbach</i> | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Auerbach MD | | | | 22d. ADDRESS 9000 Franklin Square Dr. Rosedale, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/16/87 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i> | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--------------------------------|--|-----------------|--|-------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| DELMAR | | W, | | CLARK | | Sr, | | 9-14-87 | | | | | | | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | | | |
| Male | | White | | August 8, 1912 | | 75 | | YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| West Virginia | | USA | | | | Baltimore City | | | | | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | 1636 Malvern Rd. | | Loading Dock | | Leaver Bros. | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1636 Malvern St. | | 21224 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Elmer | | Clark | | Minnie | | Makayue | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | 216-05-5679 | | Edna Burris | | 1428 Owen Dr. | | Florida | | 34619 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Sudden cardiac death | | 1 hour | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | Coronary artery disease | | Several years | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | | | | | |
| Jerome L. Fleg | | MD | | 9/14/87 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | | | |
| Jerome L. Fleg | | Francis Scott Key Medical Center | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | | | |
| Burial | | 9-17-87 | | Oak Lawn | | Baltimore Maryland | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Duda-Ruck, Inc. 7922 Wise Ave Balto Md 21222 | | SEP 18 1987 | | Julia Davidson-Randall | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These instructions are printed on the back of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST LOIS | | MIDDLE J. | | LAST CLARK | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 15, 1987 | | | | 2b. HOUR 11:57 M | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 6, 1911 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK | | | | 12b. KIND OF BUSINESS OR INDUSTRY B.N.T.C. | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY CECIL | | 13c. CITY OR TOWN PORT DEPOSIT | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE P.O. BOX 77 21904 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BENNIE MOSES | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 207-12-2782 | | 17. INFORMANT ADDRESS GEORGE A. CLARK, POBOX 77, PORT DEPOSIT, MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aspiration pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute 16 hours 4 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Renal failure, Dementia</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>8/17</u> to <u>9/15</u> 19 <u>87</u> , that (1) we last saw the deceased alive on <u>9/15</u> 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (2) <u>we</u> (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Gary Green</u> | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 9/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary Green MD | | | | 22e. ADDRESS 600 N. Wolfe Street Balto. MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE SEPT. 21, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY COKEBURY CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE PORT DEPOSIT, CECIL, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR <u>LEE A. PATTERSON & SON</u> | | | | ADDRESS PERRYVILLE, MARYLAND. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Madison Landers</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The 4 required not to be deceased certificate filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please give it to the funeral director. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND 87
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|---------------------------------------|--------------------|--|--------------|-------------------|-----------------------------------|-----------|----------------------------------|------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST RICHARD | | MIDDLE WHIT | | LAST CLARK | | 2a. DATE OF DEATH | | | MONTH SEPTEMBER | DAY 22, | YEAR 1987 | 2b. HOUR 10:50 | | MIN. M | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH 5 | | DAY 18 | | YEAR 45 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 | | | YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | | | | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF ENTER IN SUCH FACILITY, GIVE STREET ADDRESS THE JOHNS HOPKINS HOSPITAL | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1653 CLIFTVIEW AVENUE 21213 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST SANDY | | | | | | MIDDLE CLARK | | | | | | 15. MOTHER'S MAIDEN NAME FIRST UNKNOWN | | | | | | LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | | | 17. INFORMANT ADDRESS ALICE CLARK 1653 CLIFTVIEW 21213 | | | | | | | | | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> | |
| | DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC PULMONARY DISEASE</u> | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | |
|------------------------|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |

| | | |
|--|--|---|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |
|--|--|---|

| | | | | | | |
|---------|--|--|---------------|--------------|--------|-------|
| MEDICAL | 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | | | |
| | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | STREET | CITY OR TOWN | COUNTY | STATE |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased ~~play on~~ _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death.

72b. SIGNATURE *Edwards* DEGREE *MD* ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
72c. DATE SIGNED 9/24/87

| | |
|---------------------------------------|--------------|
| 72a. PHYSICIAN'S NAME (TYPE OR PRINT) | 72b. ADDRESS |
|---------------------------------------|--------------|

| | | | | | |
|--|-----------|------------------------------------|-------------------------------|--------|-------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY | STATE |
| BURIAL | 9/28/87 | GARRISON FOREST CEM | OWINGS MILLS | | MD |

| | | | |
|-----------------------|----------------------|------------------------------|---------------------------|
| 24 FUNERAL DIRECTOR | | 25a DATE REC'D. BY REGISTRAR | 25b REGISTRAR'S SIGNATURE |
| NAME | ADDRESS | SEP 25 1987 | Julia Davidson-Pendall |
| WM. C. MARCH F/H INC. | 1101 E. NORTH AVENUE | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. You should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be placed in the funeral director's possession. The funeral director should be detached for use as the burial-transit permit. Then please remove carbon paper and file in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the cause of death must be indicated on page 2.

MEDICAL CERTIFICATION

| | | | | | |
|---|---|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST <u>CLARA</u> MIDDLE <u>FRANCES</u> LAST <u>CLYDE</u> | | 2a. DATE OF DEATH MONTH <u>9</u> DAY <u>11</u> YEAR <u>1987</u> | | 2b. HOUR <u>1:48AM</u> | |
| 3. SEX <u>FEMALE</u> | 4. RACE <u>WHITE</u> | 5. DATE OF BIRTH <u>June 29, 1904</u> <u>6 29 04</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD USA</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALT. CITY</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>BALT.</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>S. BALT. GEN. HOSP.</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>self emp.</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u> |
| 13a. STATE <u>MD</u> | | 13b. COUNTY <u>AA</u> | 13c. CITY OR TOWN <u>Glen Burnie</u> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <u>125 Faywood Ct. 21061</u> |
| 14. FATHER'S NAME FIRST <u>David</u> MIDDLE <u>J.</u> LAST <u>Lewis</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Florence</u> MIDDLE <u>A.</u> LAST <u>Mac Donald</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>XXXXXXXXXX 214053547</u> | | 17. INFORMANT ADDRESS <u>Weldon E. Dungan (P.R.) Glen Burnie, MD</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METABOLIC ENCEPHALOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>LIVER FAILURE, RENAL FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>VENT. ARRHYTHMIA, CHF, ANEMIA</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-7</u> 19 <u>87</u> , to <u>9-11</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9-11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Marian Fong</u> | | | | 22c. DATE SIGNED <u>9.11.87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARIAN FONG</u> | | | | 22e. ADDRESS <u>S. BALT. GEN. HOSP.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | 23b. DATE <u>12 Sept. 1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Security Process Inc</u> | |
| 23d. LOCATION CITY OR TOWN <u>Catonsville, Balt. MD</u> | | 23e. COUNTY <u>Balt.</u> | | 23f. STATE <u>MD</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Singleton Funeral Home, Glen Burnie, MD</u> ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 15 1987</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Weldon E. Dungan</u> | |

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066848 SEP 25 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 5 5 3 2

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|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: <i>Helene</i> MIDDLE: <i>W.</i> LAST: <i>Cockey</i> | | | 2a. DATE OF DEATH MONTH: <i>09</i> DAY: <i>22</i> YEAR: <i>87</i> | | 2b. HOUR <i>2:00</i> PM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH: <i>10</i> DAY: <i>28</i> YEAR: <i>92</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>94</i> YRS | | IF UNDER 1 YEAR MONTHS: _____ DAYS: _____ |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Meray Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER | 12b. KIND OF BUSINESS OR INDUSTRY EDUCATION | |
| 13a. STATE MARYLAND | | | 13b. COUNTY HOWARD | 13c. CITY OR TOWN COLUMBIA | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX |
| 14. FATHER'S NAME FIRST: CLARENCE MIDDLE: S. LAST: WALLACE | | | 15. MOTHER'S MAIDEN NAME FIRST: JENNY MIDDLE: R. LAST: HODGES | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-18-9751A | 17. INFORMANT LOUISE NEWS ADDRESS: 5731 FOX HALL FARM ROAD CATONSVILLE, MD 21228 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b). _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c). _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>History of Pancreatitis History of Recent Cholecystectomy</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN: _____ COUNTY: _____ STATE: _____ | |
| 22a. I certify that (1) this hospital attended the deceased from <i>9/22</i> 19 <i>87</i> to <i>9/22</i> 19 <i>87</i> , that (1) (we) lost saw the deceased alive on above (1) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE <i>N. W. Todd, MD</i> | | DEGREE MD | | 22c. DATE SIGNED <i>9/22/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Nervins W. Todd, M.D.</i> | | 22e. ADDRESS <i>301 St. Paul Place Balt. MD 21202</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE <i>9/26/87</i> | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST | | 23d. LOCATION CITY OR TOWN: _____ COUNTY: _____ STATE: _____ OWINGS MILLS BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR NAME: LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228 | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

DHMH - 16 60M 7/84 (VRA 15. 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN, TO BE FILED WITHIN 72 HOURS OF DEATH. PAGE 4 MAY BE
 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by a physician and completely filled in, the funeral director, page 3
 should be detached for use as the burial/transit permit. Then page 4 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

25533

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST GEORGE L. COHEN | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 29, 1987 | | 2b. HOUR 5:17P M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1922 | | 6. AGE (IN YEARS- LAST BIRTHDAY) 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Potomac | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Max Cohen | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle (Unknown) | | 16. STREET ADDRESS / ZIP CODE 12289 Greenleaf Avenue (20854) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-1945 | | 17. INFORMANT ADDRESS Potomac, Md. 20854 | | Chasza Cohen; Wife; 12289 Greenleaf Avenue; | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 minutes 6 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Probable ischemic heart disease, severe peripheral edema, multi-system organ failure</u> | | | | | | | |
| 19a. DATE OF OPERATION 9/25/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED laryngeal cancer | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> , 19 <u>87</u> , to <u>9/29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Alan Yahanda</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/30 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Yahanda | | | | 22e. ADDRESS Dept of Surgery, Johns Hopkins | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden | | 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax; Va. | |
| 24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852 DATE RECEIVED BY REGISTRAR OCT 05 1987 | | | | | | | |

MEDICAL CERTIFICATION

67768 OCT-7 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|-----------------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED MIDDLE LAST COHEN | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 30, 1987 | | | 2b. HOUR 12:40A | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 7, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL GLASS | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE STEINBERG | | | 16. STREET ADDRESS / ZIP CODE APT. 201 6310 GREENSPRING AVE. #21209 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 212-03-2943 | | 17. INFORMANT MARK COHEN | | 18. ADDRESS UNIT 1208 1101 ST. PAUL ST. BALTO., MD 21202 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypotension</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiac failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>aortic stenosis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>long time</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>renal failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION 9/25/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED aortic stenosis | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>September 25, 1987</u> to <u>September 30, 1987</u> , that (I) (we) last saw the deceased alive on <u>September 30, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Wayne E. Garris, M.D.</u> | | | | | | | | 22c. DATE SIGNED 9/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne E. Garris, M.D. | | | | 22e. ADDRESS 22 South Green Street Bldg. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE OCT. 1, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO. MD | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 6 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, treated certificate must be notified and filed.

67568 OCT-58

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066590 SEP 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|---|---|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BENJAMIN F. Cole | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 20 87 | | 2b. HOUR 9 12 A.M. | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 9 18 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va | | 7b. CITIZEN OF WHAT COUNTRY? USA | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE 2168 Hollins St 21223 | | | | |
| 13b. STATE Md | | 13c. COUNTY Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dave Cole | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Walker | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 219-05-2083 | | 17. INFORMANT Anna Griffin | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA - PANCREAS DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) COPD - Severe | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE D. Shamsuddin M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 9/20/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. SHAMSUDDIN | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md | | 23e. DATE REC'D. BY REGISTRAR SEP 22 1987 | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages, Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, of other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25536

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis A. Coleburn | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 2, 1987 | | 2b. HOUR 9:00 PM |
| 1. SEX MALE | 4. RACE Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 13, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LOCH RAVEN VA HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brewery worker | | 12b. KIND OF BUSINESS OR INDUSTRY Brewery |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 423 N. Ellwood Ave 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alden Webster Coleburn | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Kloiber | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | 17. INFORMANT James Coleburn | | ADDRESS 82 W. Kingston Park. Balto., Md. 21220 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COVID</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15' 7 days chronic |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Intraabdominal sepsis</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Stephen L. Hull</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN L. HULL, M.D. | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 9/5/87 | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Crem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto MD | |
| 24. FUNERAL DIRECTOR John A. Moran, Inc. | | 3000 E. Balto St. Balto.; Md. 21224 | | 25a. DATE REC'D. BY REGISTRAR SEP 4 1987 | 25b. REGISTRAR'S SIGNATURE <u>Julia Davis</u> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These pages (except page 3) should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, Division of Vital Records, 201 W. Preston St., Baltimore, Md. 21201.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, or medical procedure, it must be notified to the medical examiner.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD CARLTON COLEMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 9, 1987 | | 2b. HOUR 10:16 P M |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 3 13 40 | | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK. | 12b. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WALKER COLEMAN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL ROBINSON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 214-38-2798 | | 17. INFORMANT ADDRESS JEWEL SMITH 1716 MONTEPELIER STREET | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alcoholism</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15-20 MIN</u> <u>1 week</u> <u>15 YEARS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>⊕ HIV</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> 19 <u>87</u> to <u>9/9</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>John D. Hummel</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/9/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Hummel | | 22e. ADDRESS 600 N. Wolfe St, Balt, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/18/87 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | |
| | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. These please remove carbon papers, pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. If item 21 is marked or item 18 shows any injury, other than a natural event, the medical examiner must be notified.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other than a natural event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If a may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified immediately.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. BASED NAME (TYPE OR PRINT) LEONARD E. COLEMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 15 87 | | 2b. HOUR M |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 2 4 60 | | 6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY N/A |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3516 FLIERSLIE AVENUE 21218 |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARVERITE COLEMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 240-25-9319 | | 17. INFORMANT ADDRESS NINA COLEMAN 3516 ELLERSLIE AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypercalcemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Widely metastatic anaplastic CA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Angela A Swinson MD</u> DEGREE PHYSICIAN'S NAME (TYPE OR PRINT) <u>Angela A Swinson MD</u> | | | | 22c. DATE SIGNED 9/18/87 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/22/87 | 23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. | | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Jana Davidson-Randall</u> |

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SEP 18 1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|--|---|---|---------------------------|--|
| 1. DECEASED NAME (PRINT) LOUISE COLEMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-11-87 | | 2b. HOUR 9:15 A | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 20 23 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. MONTHS DAYS HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Md | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ezell Cheek | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Foster | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-18-4950 | | 17. INFORMANT Mack Coleman | | |
| | | | | ADDRESS 2407 Chelsea Terrace | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) PACEMAKER FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) RENAL FAILURE | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/24 , 19 87 , to 9-11 , 19 87 , that (I) (we) last saw the deceased alive on 9-11 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE BICH T DUONG | | DEGREE LIBERTY MEDICAL CENTER | | 22c. DATE SIGNED 9-11-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG | | 22e. ADDRESS LIBERTY MEDICAL CENTER | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/15/87 | | 23c. NAME OF CEMETERY OR CREMATORY Md Nat Memorial Park | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Md | | 23e. DATE REC'D. BY REGISTRAR SEP 14 1987 | | 23f. REGISTRAR'S SIGNATURE Julia Anderson-Randall | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue | | | | | | |

MEDICAL CERTIFICATION

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME FIRST MIDDLE LAST Mildred Ellen Coleman | | | 2a. DATE OF DEATH MONTH DAY YEAR September 6, 1987 | | 2b. HOUR 12 ³⁵ M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 11, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEPTON HOSPITAL AND MEDICAL CENTER | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY A A Co. 13c. CITY OR TOWN Glen Burnie 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 1011 Thomas Road 21061 | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Bowen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA | | 17. INFORMANT (Son) ADDRESS James E. Harvey, Jr. Canton, Ohio 44708 | | 6956 Eastham Cr. NW | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>infected decubiti</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHF & heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>18 months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>9/6</u> <u>57</u> <u>28/27</u> <u>85</u> to <u>9/6</u> <u>87</u> <u>87</u> , that (we) last saw the deceased alive on <u>9/6</u> <u>57</u> <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>JR Gladue, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9/2/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. R. Gladue, M.D. | | | | 22e. ADDRESS 611 S. Charles Street Baltimore, Maryland 21201 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept 9, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Maryland | | |
| 24. FUNERAL DIRECTOR NAME <u>R. N. Abraham</u> Singleton Funeral Home Glen Burnie, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Lia Davidson-Randall</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. The low requires that the death certificate be retained by the hospital or attending physician. The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician in the presence of the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death. Page 1 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH25341
REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|-------|---|--|---|-------------------|--|---------|----------------|--|---|------------------|--|-------|---|--|--|-------|--|-------|-------|--|----------|------|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | MONTH | | | DAY | | | YEAR | | | 2b. HOUR | | | | | |
| Rodney | | | | | | | | | Coleman | | | | | | 9/ | | | 8/ | | | 19 87 | | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | | IF UNDER 1 YR. | | | IF UNDER 24 HRS. | | | 2c. DATE PRONOUNCED DEAD | | | MONTH | | | DAY | | | YEAR | | | 2d. HOUR | |
| Male | | Black | | 4/28/66 | | | 21 YRS. | | | | | | | | | 9/ | | | 8/ | | | 19 87 | | | P M | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| Md. | | | | USA | | | | | | | | Baltimore City, | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | | | University Hospital | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| Md. | | | | | | | | Balto. | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 911 Cherry Hill Rd. 21225 | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | | | |
| James C. Jones | | | | | | | | Mabel Coleman | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | | | | | | | | | |
| NO | | | | 220-90-2222 | | | | Mabel Coleman 911 Cherry Hill Rd. (25) | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple Gunshot Wounds | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | | | |
| | | | | | | 10:25 PM 9/8/87 | | | | | | subject shot | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | |
| | | | | | | on street front | | | | | | 918 Veronica Court, Balto. City, Md. | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | | | | | | | | | | | | | | |
| Mario F. Golle, Jr., M.D. | | | | | | Assistant MEDICAL EXAMINER | | | | | | 9/9/87 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | |
| Mario F. Golle, Jr., M.D. | | | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | | | | | 9/15/87 | | | | | | Mt. Zion Cem. | | | | | | Lansdowne MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| CHARLES A. RICE FUNERAL SERVICE, PA. 1300 EUTAW PLACE | | | | | | SEP 16 1987 | | | | | | John Davidson-Randall | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT: PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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APPROVED FOR RELEASE

CONFIDENTIAL



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

066291 SEP 18 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other trauma, the medical examiner must be notified or called.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|---------------------|---|---|--|-----------------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Trula Coleman | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 16 87 | | | | | 2b. HOUR 12:35 P | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 8 5 00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sussex Co., Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CENTURY NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN MURDOCK | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MURDOCK | | | | | 13e. STREET ADDRESS / ZIP CODE 102 NORTH PACA ST. 21202 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-54-2490 | | 17. INFORMANT ADDRESS EDWARD R. WEST JR. 7004 RUDISILL CT | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/16, 19 87, to 9/16, 19 87, that (I) (we) last saw the deceased alive on 9/16, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Adriana Nube | | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) URIBE | | | | | | 22e. ADDRESS 22 S. Greene St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 922/87 | | 23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR Gregory O. Dye, Jr. | | | | | | ADDRESS 4004 Doty Hgts. | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|---|--|
| 2. DECEASED NAME (TYPE OR PRINT) <u>Maggie</u> | | | 3. DATE OF DEATH MONTH <u>9</u> DAY <u>11</u> YEAR <u>87</u> | | | 4. HOUR <u>2:30 PM</u> | | | | |
| 5. SEX <u>Female</u> | | 6. RACE <u>Black</u> | | 7. DATE OF BIRTH MONTH <u>11</u> DAY <u>8</u> YEAR <u>94</u> | | 8. AGE YEARS <u>92</u> | | 9. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> | | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore</u> | | 11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 13. BALTIMORE CITY OR COUNTY OF DEATH <u>County Balto. City MD.</u> | | | | |
| 14. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hospital of Baltimore</u> | | | | 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 17. KIND OF BUSINESS OR INDUSTRY | | |
| 18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 18a. STATE <u>MD</u> | | | 18b. COUNTY <u>Baltimore</u> | | 18c. CITY OR TOWN <u>Balto. City</u> | | 18d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18e. STREET ADDRESS / ZIP CODE <u>3503 Grantley Rd. 21215</u> | |
| 19. FATHER'S NAME FIRST <u>Abb</u> MIDDLE <u>Satterfield</u> LAST <u></u> | | | 20. MOTHER'S MAIDEN NAME FIRST <u>Frances</u> MIDDLE <u>Jones</u> LAST <u></u> | | | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 22. SOCIAL SECURITY NO. <u>238-09-6361</u> | | | 23. INFORMANT <u>Y. Kim</u> ADDRESS <u>40 Sinai Hospital</u> | | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic heart disease</u> <u>Many years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac arrhythmia</u> <u>Years.</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | | |
| 25. DATE OF OPERATION | | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 34. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 35. I certify that (I) (this hospital) attended the deceased from <u>8/29/87</u> , 19 <u>87</u> , to <u>9/11/87</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>9/11/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | | | | | | |
| 36. SIGNATURE <u>Y. Kim</u> | | | | | | 37. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 38. DATE SIGNED <u>9/11/87</u> | | |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Youngmee Kim</u> | | | 40. ADDRESS <u>40 Sinai Hospital of Baltimore</u> | | | | | | | |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 42. DATE <u>9/15/87</u> | | 43. NAME OF CEMETERY OR CREMATORY <u>Md. National Park</u> | | 44. LOCATION CITY OR TOWN COUNTY STATE <u>Laurel Md</u> | | | |
| 45. FUNERAL DIRECTOR NAME <u>C. Wainwright</u> ADDRESS <u>2700 Edmondson Ave.</u> | | | | | | 46. DATE REC'D BY REGISTRAR <u>SEP 14 1987</u> | | 47. REGISTRAR'S SIGNATURE <u>Julia D. ...</u> | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25544

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Tyonna Savina Collins</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>09 11 87</i> | | | 2b. HOUR <i>5:05PM</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>8 27 87</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>15</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>U. of Maryland Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>none</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. CITY OR TOWN <i>Baltimore</i> | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Thayne Collins</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Theresa Wilkens</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT ADDRESS <i>Theresa Wilkens 1 N. Monroe St.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Staphylococcal pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a <i>prematurity</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>September 1</i> 19 <i>87</i> to <i>September 11</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>September 11</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Rose Marie Viscardi MD</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>9/11/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rose Marie Viscardi</i> | | | | 22e. ADDRESS <i>U. Maryland Hospital 225 S. Greene St.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>9-16-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Brown-Thompson F.H.</i> | | | | ADDRESS <i>P.O. Box 4433</i> | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 15 1987</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FINAL PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.


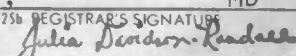
Item 18a, 20, 21b, c, d, e, f, 22a 10-27-87 dw

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---------------------|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM A. COLLINS | | | 2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 9 28 1987 | | | 2b. HOUR M <input type="checkbox"/> P <input type="checkbox"/> 7:30 | | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH 4 DAY 12 YEAR 51 | 6. AGE (IN YEARS) LAST BIRTHDAY 36 YRS. | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD MONTH 9 DAY 28 YEAR 1987 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1312 Edmondson Ave. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 13a. STATE MD | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. STREET ADDRESS 1312 W. EDMONDSON AVE. 21217 | |
| 14. FATHER'S NAME FIRST LEROEY MIDDLE COLLINS LAST COLLINS | | | 15. MOTHER'S MAIDEN NAME FIRST AURETTA MIDDLE BROWN LAST BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-56-7244 | | 17. INFORMANT ADDRESS AURETTA COLLINS 808 W. LEXINGTON STREET | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Narcotic intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9-28 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject used drugs | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET 1312 Edmondson Ave. CITY OR TOWN Baltimore, MD COUNTY MD STATE MD | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) Deputy Chief | | MEDICAL EXAMINER | | DATE SIGNED 9-29-87 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY | | 23d. LOCATION CITY OR TOWN LANDSOWNE, MD COUNTY MD STATE MD | | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. ADDRESS 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR OCT - 2 1987 | | 25b. REGISTRAR'S SIGNATURE  | | |

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066013 SEP 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) George E. Colona, Jr | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 13 1987 | | | 2b. HOUR M | | | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 3 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7207 Valley Country Court | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 7207 Valley Country Court Apt 21208 B4 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George E. Colona | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Harris | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes | | | 16b. SOCIAL SECURITY NO. 213-26-1023 | | | 17. INFORMANT ADDRESS Jeannette Colona 7207 Valley Country Ct apt B4 | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>10 yr</u> | |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Alcoholism

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-3</u> , 19 <u>82</u> , to <u>9-14</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5-28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>H. Gerald Oster</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9-15-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. Gerald Oster</u> | | | | 22e. ADDRESS <u>3635 Old Court Rd</u> | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | |
|--|--|----------------------|--|--|--|--|--|

| | | | | | |
|--|--|--|--|---|--|
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | |
|--|--|--|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

NO 81 532 C 1 0 0 0 0

066308 SEP 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Baby BOY CONNOR | | | 2a. DATE OF DEATH MONTH 7 - DAY 2 - YEAR 87 | | 2b. HOUR 11:54 AM |
| 3. SEX MALE | 4. RACE Black | 5. DATE OF BIRTH MONTH 7 - DAY 2 - YEAR 87 | | 6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS | IF UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY Harford | 13c. CITY OR TOWN Bel Air | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Charles MIDDLE Walter LAST CONNOR | | 15. MOTHER'S MAIDEN NAME FIRST Charlene MIDDLE CONNOR LAST CONNOR | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |

18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 2 , 19 87 , to July 2 , 19 87 , that (I) (we) lost saw the deceased alive on July 2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Robert A. Stover | | DEGREE MD | 22c. DATE SIGNED 7/2/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | 23b. DATE 9-17-87 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR NAME State Anatomy Board | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1987 | |
| ADDRESS Balto., Md. | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified of office.

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SEP 9 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to cremation, entombment, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25549

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST RUDOLPH | | MIDDLE CONTEE | | LAST CONTEE | | 2a. DATE OF DEATH MONTH DAY YEAR 9 12 87 | | 2b. HOUR 4:11 AM | |
| 3 SEX MALE | | 4 RACE BLACK | | 5 DATE OF BIRTH MONTH DAY YEAR 7 22 32 | | 6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS | | 7a. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7b. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE BALTO. MD. 2014 PRESBURY ST. 21217 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST EARL CONTEE | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSA MATTHEWS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO. | | | | 16b. SOCIAL SECURITY NO. 219-84-4599 | | 17. INFORMANT BALTIMORE, MD. 21206 SPENCER CONTEE 5316 GOODNOW RD. APT. F | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Severe dehydration; Ch. renal failure. Diabetes; Malnutrition. Emaciation</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-10-1987</u> to <u>9-12-1987</u> , that (I) (we) lost saw the deceased alive on <u>9-11-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>DSS + lpo</u> | | | | DEGREE | | | | 22c. DATE SIGNED 9-12-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DARSHAN. S. SALUJA | | | | 22e. ADDRESS 1600 MT Royal Ave, Balto 21217 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/17/1987 | | 23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | | | | |
| 24. FUNERAL HOME OR NAME ADDRESS NUTTER FUNERAL HOMES, INC, 21216 2501 GWYNNS FALLS PKWY, BALTIMORE, MD. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rudner</u> | | | | | |

MEDICAL CERTIFICATION

76 81 432 88 2820

064995 SEP 9 1987

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25350

REG. NO.

| | | | | | | | | | | | | | | | |
|--|------------------------------|------------------|---|---|--------------------------------------|----------------------------------|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. DATE OF DEATH | | | 2c. DATE OF DEATH | | | 2d. DATE OF DEATH | | | |
| GLENN L. COOK | | | 9 2 19 87 | | | 9 2 19 87 | | | 9 2 19 87 | | | 9 2 19 87 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | | 7d. DATE PRONOUNCED DEAD | | | 7e. DATE PRONOUNCED DEAD | | | |
| MALE | BLACK | 11 03 1948 | 38 YRS. | | | 9 2 19 87 | | | 9 2 19 87 | | | 9 2 19 87 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | |
| S. CAROLINA | U. S. A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore City | | | | | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. LINE OF BUSINESS (INDUSTRY) | | | | | | | | | |
| 1405 Kingsway | | | ATTORNEY | | | JUSTICE DEPT. | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | |
| MARYLAND | | | | | | BALTIMORE | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | BALTIMORE, MD. 1405 KINGSWAY ROAD 21218 | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| ERNEST COOK | | | ARLETHIA ABLE | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | | | |
| NO | | | 215-46-6243 | | | MRS. ARLETHIA A. COOK | | | BALTIMORE, MD. | | | 2928 EDMONDSON AVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | | | | | |
| (b) <u>Alcoholism</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | HEAD & ABDO YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| Mario F. Golle, Jr., M.D. | | | | Assistant | | | | 9/2/87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | BALTO. MD. | | | | | | | |
| Mario F. Golle, Jr., M.D. | | | | 111 Penn St. | | | | Balto. MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN | | | |
| ENTOMBMENT | | | | 9/8/1987 | | | | ARBUTUS MEM. PK. | | | | BALTIMORE, MD. | | | |
| 24. FUNERAL HOME | | | | 25a. DATE REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| NUTTER FUNERAL HOMES, INC. | | | | SEP 08 1987 | | | | | | | | | | | |
| 2501 GWYNNS FALLS PKWY. BALTO. MD. 21216 | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM "PM-3" RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))

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065243 SEP 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25551

| | | | | | | | | |
|--|-------------------------|---|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Norman Cook | | | 2a. DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 2 19 87 | | | 2b. HOUR M | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 08-14-1932 | 6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 2 19 87 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Deleware | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY Transport |
| 13a. STATE Del. | | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Dover | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS RD 5 Box 700 | | | 99999 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Raymond - Cooke | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther - Short | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-18-8858 | | 17. INFORMANT ADDRESS Mrs. Anna Cook (same as 13) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive & arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i> | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED 9/2/87 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. | | | ADDRESS 111 Penn St. Balto.MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-6-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Sharon Hill Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dover Kent Del. | |
| 24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO | | | | ADDRESS SEVERNA PARK, MD. 21146 | | 25a. DATE REC'D. BY REGISTRAR SEP 04 1987 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH - 17
(VR A15 ME (5))

002543 SEP 14 83

SEVERINA TALK WITH STING
ROBERT S. BARNARD

SEP 14 1983

065719 SEP 16 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25552

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERNON A COOK | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 11 87 | | 2b. HOUR 23:14 M |
| 3. SEX male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 07 10 49 | | 6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK II | | 12b. KIND OF BUSINESS OR INDUSTRY STATE MD |
| 13a. STATE MD | | 13b. CITY OR TOWN Baltimore | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 707 Linnard Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST NATHAN COOK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARITA LEE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b. SOCIAL SECURITY NO. 219-56-7356 | 17. INFORMANT ADDRESS Carita Cook 707 Linnard St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA - PNEUMOCYSTIS CARINI DUE TO, OR AS A CONSEQUENCE OF (b) ACQUIRED IMMUNE DEFICIENCY SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/7 , 19 87 , to 9/11 , 19 87 ; that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Latha R Pillai | | DEGREE MD | | 22c. DATE SIGNED 9/11/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LATHA PILLAI | | 22e. ADDRESS ST AGNES HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/15/87 | 23c. NAME OF CEMETERY OR CREMATORY MAGDOON | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD | |
| 24. FUNERAL DIRECTOR NAME Marshall P. Hayes | | ADDRESS 638 N. Gilman St | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | 25b. REGISTRAR'S SIGNATURE Julia Bender-Ridder |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

066538 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7a DATE OF DEATH MONTH DAY YEAR 9 19 87 7b HOUR M

1. DECEASED NAME FIRST MIDDLE LAST MARY F. COOPER

3 SEX FEMALE

4 RACE BLACK

5. DATE OF BIRTH MONTH DAY YEAR 4 26 12

6 AGE (IN YEARS LAST BIRTHDAY) 75

IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD

7b CITIZEN OF WHAT COUNTRY? U S A

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD

10 CITY OR TOWN OF DEATH BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 622 EAST 30th STREET

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED

12b KIND OF BUSINESS OR INDUSTRY N/A

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO.

13c. CITY OR TOWN YES ☒ NO ☐

13d INSIDE CITY LIMITS? 13e STREET ADDRESS / ZIP CODE 622 EAST 30th STREET 21218

14 FATHER'S NAME FIRST MIDDLE LAST ALBERT COOPER

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO

16b SOCIAL SECURITY NO. 218-76-4584

17 INFORMANT ADDRESS

DERORAH D. JOSEPH 622 EAST 30th STREET

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC CARCINOMA TO

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) THE LIVER, Primary

DUE TO, OR AS A CONSEQUENCE OF

(c) UNKNOWN

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 9/11, 1987 to 9/19, 1987, that (I) (we) last saw the deceased alive on 9/19, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT) A.C. ENRIQUE

22e ADDRESS

2435 W. BELVEDERE AVE 21215

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

23b DATE 9/23/87

23c NAME OF CEMETERY OR CREMATORY ARBITIUS MEMORIA PK

23d LOCATION CITY OR TOWN COUNTY STATE ARBITIUS MD

24 FUNERAL DIRECTOR

NAME WM. C. MARCH F/H INC ADDRESS 1101 E NORTH AVENUE

25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE

SEP 22 1987

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SEP 23 1961

067319 OCT-1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1-
STATE
REGISTRAR

| | | | | | | |
|---|--|---|---|--|--|--|
| DECEASED NAME (TYPE OR PRINT) TERRELL L COOPER | | | 2a DATE OF DEATH MONTH DAY YEAR 09 27 87 | | 2b HOUR 7:15 AM | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 08 14 17 | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS MONTHS DAYS HOURS MIN | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven V.A. Hospital | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 13a STATE MD | | 13b COUNTY Hartford | | 13c CITY OR TOWN Havva de Grace | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Ernest Cooper | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maud Bayless | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OR DATES) Yes WW II | | 16b SOCIAL SECURITY NO. 213-12-3378 | | 17 INFORMANT ADDRESS Artie E. Cooper same as above | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic colon cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: dehydration | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from SEPTEMBER 24 , 19 87 , to SEPTEMBER 29 , 19 87 that (I) (we) lost saw the deceased alive on SEPTEMBER 26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE James D. Dike, Jr. | | | | 22c DATE SIGNED 9/27/87 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) JAMES D. DIKE, MD | | | | 22e ADDRESS LOCH RAVEN VA MEDICAL CENTER | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b DATE 9/28/87 | | 23c NAME OF CEMETERY OR CREMATORY R. A. Ferris & Co | | |
| 23d LOCATION CITY OR TOWN COUNTY STATE West Chester Chester Pa. | | 24 FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 | | | | |
| 25a DATE REC'D BY REGISTRAR SEP 30 1987 | | | | 25b REGISTRAR'S SIGNATURE Julia Davidson-Rudman | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies to pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

085318 OCT-1 87

066803 SEP 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) William COPLAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/21/87 | | 2b. HOUR MIN. 12:46 P |
| 3. SEX M MALE | 4. RACE W HITE | 5. DATE OF BIRTH MONTH DAY YEAR 01 17 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. B County CITY MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANUFACTURER | | 12b. KIND OF BUSINESS OR INDUSTRY NECKWEAR |
| 13a. STATE MD | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2601 MADISON AVE. #21217 |
| 14. FATHER'S NAME FIRST MIDDLE LAST ELIAS COPLAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ZELDA PATZ | | 16. APT. 306 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-03-7890 | | 17. INFORMANT MRS. FLORENCE COPLAN 2423 LIGHTFOOT DR. BALTO., MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/20 19 87 to 9/21 19 87 that (I) (we) last saw the deceased alive on 9/21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Greg Redmann | | DEGREE MD | | 22c. DATE SIGNED 9/21/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Greg Redmann | | 22e. ADDRESS Sinai Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE SEPT. 23, 1987 | 23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The low requirement for death certificate be executed within 24 hours after death. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

BP

Central
New York
State

12 January
1944
State of New York
Department of Social Welfare

Case No. 100-10000
Carpenter, John

100-10000
Carpenter, John
100-10000
Carpenter, John

064952-SEP-987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|-------------------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY CORNETT | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 1 87 | | 2b. HOUR MIN. 12 55 AM | | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 11 10 39 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 47 | | 7. IF UNDER 1 YEAR HOURS MIN. --- | | 8. IF UNDER 24 HRS. HOURS MIN. --- | |
| 9. BIRTHPLACE (STATE OR FOREIGN) OHIO | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 13. CITY OR TOWN OF DEATH BALTIMORE | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 16. KIND OF BUSINESS OR INDUSTRY --- | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE MARYLAND | | | | | | 17b. COUNTY BALTIMORE | | 17c. CITY OR TOWN BALTIMORE | | 17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 18. FATHER'S NAME FIRST MIDDLE LAST Unknown Gadis | | | | | | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | | 21. SOCIAL SECURITY NO. 268-26-0857 | | 22. INFORMANT ADDRESS Danny Cornett 1810 Dover Street 21223 | | | |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic cirrhosis, etiology undetermined Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (d) --- | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic cholecystitis & cholelithiasis | | | | | | | | | | | |
| 24. DATE OF OPERATION 9/8/87 | | | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic cholecystitis & cholelithiasis | | | | 26. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR --- P.M. 19 | | | | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 33. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 34. I certify that (a) this hospital attended the deceased from 9/1/87 to 9/1/87 that (b) I saw the deceased alive on 9/1/87 and that in my own opinion death occurred on the date and hour and from the causes stated above. (If deceased did not live the body after death) | | | | | | | | | | | |
| 35. SIGNATURE William J. Hicken MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 36. PHYSICIAN'S NAME (TYPE OR PRINT) WM J HICKEN | | | | | | 37. ADDRESS St Agnes Hospital | | | | | |
| 38. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 39. DATE 9/8/87 | | 40. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 41. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. A.A. Maryland | |
| 42. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | | | | | 43. ADDRESS 4107 WILKENS AVE. | | 44. DATE REC'D. BY REGISTRAR SEP 8 1987 | | 45. REGISTRAR'S SIGNATURE --- | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The plate must be removed from the certificate. The plate may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the removal of the body from the hospital. The plate may be removed at any time. IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be called for an autopsy.

BP

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(VRA 15, 4)

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH25557
REG. NO.

| | | | | | | | | |
|--|--|---|---|---|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Georgiana Cornish | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 11 87 | | | 2b. HOUR 4¹⁰ PM | | |
| 3. SEX F | | 4. RACE B 2 | | 5. DATE OF BIRTH MONTH DAY YEAR 5 12 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wm. Stewart | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgiana Young | | 16. ADDRESS 3011 Matthews St | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown | | 16b. SOCIAL SECURITY NO. 216-03-1951 | | 17. INFORMANT William Stewart | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 Advanced laryngeal CA, Breast CA | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10 , 19 87 , to 9/11 , 19 87 , that (I) (we) lost above the deceased alive on 9/11 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | |
| 22b. SIGNATURE Faith SarFarazi MD | | | | DEGREE MD | | 22c. DATE SIGNED 9/11/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Faith SarFarazi MD | | | | 22e. ADDRESS Sinai Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR NAME Brown-Thompson F. H. | | | | ADDRESS P.O. Box 4433 | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE Davidson-Randall |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|---|--|-------------------------------------|--|---|--|---------------------------------|-----------------------------------|-----|----------------------------------|--------------------|
| 1. FOR STATE REGISTRAR | | DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 7b. HOUR |
| | | Samuel W. Cornish Sr. | | | | | 9 | 18 | 87 | | 7 ³⁰ AM |
| 3. SEX | M | 4. RACE | B 2 | 5. DATE OF BIRTH | MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| | | | | 7 | 6 | 24 | 63 | YRS. | | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | MD | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TIME OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| | | Lock Raven VAMC, Baltimore | | | Retired | | | N/A | | | |
| 13a. STATE | MD | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| | | | | Balto | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2269 W. Balto. St. 21223 | | | | | |
| 14. FATHER'S NAME | BRADFORD | 15. MOTHER'S MAIDEN NAME | LILLIE PALMER | | | | | | | | |
| | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | yes | 16b. SOCIAL SECURITY NO. | 215-16-1274 | | | | | | | | |
| | | | 17. INFORMANT ADDRESS | | | | | | | | |
| | | | Janie Cornish 2269 W. Balto. Street | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| (b) myocardial infarction | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Candida albicans sepsis | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| Renal failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 70a. AUTOPSY? | | 70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 71a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 71b. TIME OF INJURY | | | 71c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| | P.M. 19 | | | | | | | | | | |
| 71d. INJURY OCCURRED | 71e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 71f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 72a. I certify that (I) (this hospital) attended the deceased from 9/18, 19 87, to 9/18, 19 87, that (I) (we) last saw the deceased alive on 9/18, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 72b. SIGNATURE | | | | | | | | | | 72c. DATE SIGNED | |
| Kimberly A. McCrea, MD. | | | | | | | | | | | |
| 72d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 72e. ADDRESS | |
| Kimberly A. McCrea MD | | | | | | | | | | 22. S. Greene St. Balt. MD 21222 | |
| 73a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 73b. DATE | | 73c. NAME OF CEMETERY OR CREMATORY | | 73d. LOCATION | | 73e. DATE REC'D BY REGISTRAR | | | | |
| BURIAL | 9/23/87 | | GARRISON FOREST | | OWINGS MILLS, MD | | SEP 22 1987 | | | | |
| 74. FUNERAL DIRECTOR | | | | | | | 75a. DATE REC'D BY REGISTRAR | | | | |
| WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | | | | 75b. REGISTRAR'S SIGNATURE | | | | |
| | | | | | | | Davidson-Randall | | | | |

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SEP 53 81

066739 SEP 24 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARY COSBY | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20, 1987 | | 2b. HOUR 3:49 ^P M | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 1 24 16 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1523 E. 28th STREET 21218 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH COSBY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BROWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 215-09-3896 | | 17. INFORMANT ADDRESS ANNIE COSBY 1523 E. 28th STREET 21218 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARACAE INJURY</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>SUBDURAL HEMATOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PROSTATE CANCER</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 36 hr 1 yr |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/19/87</u> , 19 <u>87</u> , to <u>9/24/87</u> , 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>9/24/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>James Corkum</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>9/20/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES M. CORKUM</u> | | 22e. ADDRESS <u>Johns Hopkins Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY CREST LAWN CEMETERY | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO. MD | | | | | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MD 21201

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SEP 23 1961

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

064856 SEP-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25500

| | | | | | |
|---|--|---|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOUR MIN. | |
| Mary Catherine Covey | | 9 2 87 | | 11 30 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Female | White | 4-10-1906 | 81 | Balto. City MD | |
| 7a. BIRTHPLACE | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | U.S.A. | NEVER MARRIED | Balto. City MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Balto. | 1000 S. Caton Ave. 21229 | Housewife | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | | Balto. | YES | 6609 Eastern Pkwy. 21214 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | | | |
| Thomas Spurrier | Anne Quarles | 216-03-9727 D | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | |
| No | 216-03-9727 D | Helen T. Heisler, 4406 Bedford Pl. 21218 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cardio-vascular | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) 1970 B7 ED injury | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES | YES | | |
| 21a. ACCIDENT WAS UNDERLYING | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED | | | |
| OR CONTRIBUTING CAUSE OF DEATH | HOUR A.M. MONTH DAY YEAR | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY | 21f. LOCATION | | | |
| WHILE AT WORK | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | 22b. SIGNATURE | | | | |
| above, (I) (we) (did) (did not) view the body after death. | DEGREE | | | | |
| | ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN | | | | |
| 22c. PHYSICIAN'S NAME | 22d. ADDRESS | | | | |
| GEORGE ANGE | 350 Wilkes Ave Baltimore | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 9-5-87 | Druid Ridge | Balto., Md. | | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Leonard J. Ruck, Inc., 5305 Harford Rd. | SEP 04 1987 | | John Davidson-Randall | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate and page 3 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

064828 SEP-88

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "SEP 88" are visible.]

067233 SEP 20 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or else.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDNA ESTELLA COX | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 20 87 | | | 2b. HOUR M | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 3 15 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3003 PIEDMONT AVENUE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE 3003 Piedmont Avenue 21216 | | | 13f. BALTIMORE, Md. | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John C. Barnes | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella L. Gibson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-16-1768 | | 17. INFORMANT MR. FURLOW COX ADDRESS BALTIMORE, MARYLAND 3003 PIEDMONT AVENUE 21216 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE <u>James A. Priest, M.D.</u> | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 9-24-87 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. PRIEST, M.D. | | | | | | 22e. ADDRESS 3101 Gwynns Falls Pkwy. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9/25/1987 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VET. CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | |
| 24. FUNERAL HOME NAME ADDRESS 2501 Gwynns Falls Pkwy. BALTIMORE, MD. 21216 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE SEP 28 1987 | |

BP

007533 SEP 30 01

SEP 28 1901

065128 SEP 10 1987, Film G631 9/17/87 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SHIRKEY COX | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 05 87 | | 2b. HOUR 9⁰⁵ PM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 08 31 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) n/a | | 12b. KIND OF BUSINESS OR INDUSTRY Homemaker | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Stein | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Marie Hartline | | 13e. STREET ADDRESS / ZIP CODE 115 W Fort Ave 21230 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216285223 | | 17. INFORMANT ADDRESS Cox Bernadine Sore | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatorenal Syndrome DUE TO, OR AS A CONSEQUENCE OF (b) Hypotension DUE TO, OR AS A CONSEQUENCE OF (c) Coronary | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/05/87 19____ to 8/05/87 19____, that (I) (we) lost saw the deceased alive on 8/05/87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE Caldwell | | | | DEGREE MD | | 22c. DATE SIGNED 9/05/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A.Co.Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Balto.Md.21230 McCully Funeral Home, 130 E. Fort Ave. | | | | 25. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE SEP 09 1987 <i>John D. ...</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be placed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed page 1 and 2 and file with the funeral director. Page 4 should be filed with the funeral director. Page 5 should be filed with the funeral director. Page 6 should be filed with the funeral director. Page 7 should be filed with the funeral director. Page 8 should be filed with the funeral director. Page 9 should be filed with the funeral director. Page 10 should be filed with the funeral director. Page 11 should be filed with the funeral director. Page 12 should be filed with the funeral director. Page 13 should be filed with the funeral director. Page 14 should be filed with the funeral director. Page 15 should be filed with the funeral director. Page 16 should be filed with the funeral director. Page 17 should be filed with the funeral director. Page 18 should be filed with the funeral director. Page 19 should be filed with the funeral director. Page 20 should be filed with the funeral director. Page 21 should be filed with the funeral director. Page 22 should be filed with the funeral director. Page 23 should be filed with the funeral director. Page 24 should be filed with the funeral director. Page 25 should be filed with the funeral director. Page 26 should be filed with the funeral director. Page 27 should be filed with the funeral director. Page 28 should be filed with the funeral director. Page 29 should be filed with the funeral director. Page 30 should be filed with the funeral director. Page 31 should be filed with the funeral director. Page 32 should be filed with the funeral director. Page 33 should be filed with the funeral director. Page 34 should be filed with the funeral director. Page 35 should be filed with the funeral director. Page 36 should be filed with the funeral director. Page 37 should be filed with the funeral director. Page 38 should be filed with the funeral director. Page 39 should be filed with the funeral director. Page 40 should be filed with the funeral director. Page 41 should be filed with the funeral director. Page 42 should be filed with the funeral director. Page 43 should be filed with the funeral director. Page 44 should be filed with the funeral director. Page 45 should be filed with the funeral director. Page 46 should be filed with the funeral director. Page 47 should be filed with the funeral director. Page 48 should be filed with the funeral director. Page 49 should be filed with the funeral director. Page 50 should be filed with the funeral director. Page 51 should be filed with the funeral director. Page 52 should be filed with the funeral director. Page 53 should be filed with the funeral director. Page 54 should be filed with the funeral director. Page 55 should be filed with the funeral director. Page 56 should be filed with the funeral director. Page 57 should be filed with the funeral director. Page 58 should be filed with the funeral director. Page 59 should be filed with the funeral director. Page 60 should be filed with the funeral director. Page 61 should be filed with the funeral director. Page 62 should be filed with the funeral director. Page 63 should be filed with the funeral director. Page 64 should be filed with the funeral director. Page 65 should be filed with the funeral director. Page 66 should be filed with the funeral director. Page 67 should be filed with the funeral director. Page 68 should be filed with the funeral director. Page 69 should be filed with the funeral director. Page 70 should be filed with the funeral director. Page 71 should be filed with the funeral director. Page 72 should be filed with the funeral director. Page 73 should be filed with the funeral director. Page 74 should be filed with the funeral director. Page 75 should be filed with the funeral director. Page 76 should be filed with the funeral director. Page 77 should be filed with the funeral director. Page 78 should be filed with the funeral director. Page 79 should be filed with the funeral director. Page 80 should be filed with the funeral director. Page 81 should be filed with the funeral director. Page 82 should be filed with the funeral director. Page 83 should be filed with the funeral director. Page 84 should be filed with the funeral director. Page 85 should be filed with the funeral director. Page 86 should be filed with the funeral director. Page 87 should be filed with the funeral director. Page 88 should be filed with the funeral director. Page 89 should be filed with the funeral director. Page 90 should be filed with the funeral director. Page 91 should be filed with the funeral director. Page 92 should be filed with the funeral director. Page 93 should be filed with the funeral director. Page 94 should be filed with the funeral director. Page 95 should be filed with the funeral director. Page 96 should be filed with the funeral director. Page 97 should be filed with the funeral director. Page 98 should be filed with the funeral director. Page 99 should be filed with the funeral director. Page 100 should be filed with the funeral director.

062150 SEP 10 81

[Faint, mostly illegible handwritten text on lined paper, possibly bleed-through from the reverse side. Some words like "LIFE" and "BET" are visible.]

SEP 09 1981

65654 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Willie M. Cox | | | 2a. DATE OF DEATH MONTH 09 DAY 12 YEAR 87 | | 2b. HOUR 10:58^P |
| 3. SEX F | 4. RACE Black | 5. DATE OF BIRTH MONTH 12 DAY 12 YEAR 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mo. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY House |
| 13a. STATE Md. | | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST John MIDDLE Cox LAST Cox | | | 15. MOTHER'S MAIDEN NAME FIRST Caldonia MIDDLE Caldonia LAST Caldonia | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 227-72-4533 | | 17. INFORMANT ADDRESS Ms. Sarah Knight 2558 W. Fayette St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12 , 19 87 , to 9/12 , 19 87 , that (I) (we) last saw the deceased alive on 9/12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE A. URBES | | | | 22c. DATE SIGNED 9/13/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. URBES | | | | 22e. ADDRESS 22 S. Greene St. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-16-87 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn | |
| 23d. LOCATION CITY OR TOWN Balto | | COUNTY Md. | | STATE | |
| 24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons ADDRESS 1701 Laurens | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

MEDICAL CERTIFICATION

9

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene pursuant to regulations. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

022621 SEP 12 61

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report with several paragraphs.]

065463 SEP 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

| | | | | | |
|--|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERALDINE CRADDOCK | | 2a DATE OF DEATH MONTH DAY YEAR 9 10 87 | | 2b HOUR M | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5 DATE OF BIRTH MONTH DAY YEAR 6 19 24 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 AGE (IN YEARS (LAST BIRTHDAY)) 63 YRS. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1008 BONAPARTE AVENUE | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 13a STATE MD | | 13b COUNTY | | 13c CITY OR TOWN BALTO. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST EDWARD | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST URSULA KEARNS | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b SOCIAL SECURITY NO. 038-18-7747 | | 17 INFORMANT JOHN A. CRADDOCK 1008 BONAPARTE AVENUE | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18 | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>9/12</u> 19 <u>86</u> to <u>9/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/14</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b SIGNATURE <u>Davis M Hahn</u> | | DEGREE MD | | 22c DATE SIGNED 9/10/87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Davis M Hahn</u> | | 22e ADDRESS <u>5801 Loch Raven Blvd</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 9/14/87 | | 23c NAME OF CEMETERY OR CREMATORY BALTIMORE NAT'L CEM. | |
| 23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD | | 24 FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | |
| 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE <u>Julia Friedman-Pedraza</u> | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

BP

082400 SEP 12 01

SEP 14 01

067572 OCT-5

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) 1- CHARLES (Howard) CRAWFORD, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 29 87 | | | 2b. HOUR 1442M | | | |
| 3. SEX MALE | | 4. RACE C I | | 5. DATE OF BIRTH MONTH DAY YEAR 6 24 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U OF MARYLAND HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Glass-Glazer | | 12b. KIND OF BUSINESS OR INDUSTRY Glass & Window Factory | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1514 W. PRATT ST, BALI 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES CRAWFORD | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE ENNIS | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | |
| 16b. SOCIAL SECURITY NO. 219-03-6450 | | | 17. INFORMANT James L. Crawford | | | ADDRESS 1514 W. Pratt St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PANCREATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a LIVER DISEASE 2° TO ALCOHOL AND METASTATIC CANCER | | | | | | | | | |
| 19a. DATE OF OPERATION 9/28/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED METABOLIC ACIDOSIS/SEPSIS | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/27 19 87 to 9/29 19 87, that (I) (we) last saw the deceased alive on 9/29/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Michael Sauter | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/29/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL SAUTER | | | | 22e. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. A.A. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR OCT - 2 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

167273 OCT-2 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1-
FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Audrey M Cromwell | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 8 87 | | 2b. HOUR 1850 M |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 1 27 32 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD. | | | 13b. COUNTY Balto | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert M Rebstock | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie R Spencer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-28-4174 | | 17. INFORMANT ADDRESS John Cromwell 715 Woodsdale Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a Diabetes Mellitus | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Sambanday Baskaran MD | | | | 22c. DATE SIGNED 9-8-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMBANDAY BASKARAN | | | | 22e. ADDRESS 3455 Wilkens Ave Baltimore MD 21229 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept 12, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Howard Maryland | | 24. FUNERAL DIRECTOR Harry H Witzke 4112 Old Columbia Pike Ellicott City | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudner | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) MYREE CROSBY | | | 2a DATE OF DEATH MONTH DAY YEAR 9/23/87 | | 2b HOUR 540AM |
| 3 SEX F | 4 RACE W | 5 DATE OF BIRTH MONTH DAY YEAR 12/19/03 | | 6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b CITIZEN OF WHAT COUNTRY? US | 8 MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH 611 S. Charles St. BALT, MD | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Med Center | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY BALT. 13c CITY OR TOWN BALT. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 611 S. Charles St. 21230 | |
| 14 FATHER'S NAME FIRST NOT GIVEN MIDDLE William LAST Tate | | 15 MOTHER'S MAIDEN NAME FIRST NOT GIVEN MIDDLE Allice LAST Callahan | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b SOCIAL SECURITY NO 220-03-9591 | | 17 INFORMANT ADDRESS Dorothes Thomas 1403 McCulloh St. 21217 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Multiple emphysema DUE TO, OR AS A CONSEQUENCE OF: (c) multiple decubiti / Sepsis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, Peripheral Vascular Disease | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE Michael C. Kozak | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED 9/23/87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL KAZAK | | 22e ADDRESS 36810 BONNIE Ridge AVE BALT. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 9/26/87 | | 23c NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. | |
| 23d LOCATION CITY OR TOWN COUNTY STATE Brooklyn Md. | | 24 FUNERAL DIRECTOR NAME ADDRESS Chas. A. Rice FSPA 1300 Eutaw Place | | | |
| 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE SEP 29 1987 Julia Gordon-Randall | | | |

The following is a list of the
 names of the persons who
 were present at the meeting
 held on the 1st day of
 January, 1902, at the
 residence of Mr. J. H.

The following is a list of the
 names of the persons who
 were present at the meeting
 held on the 1st day of
 January, 1902, at the
 residence of Mr. J. H.

067248 SEP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their place is above on both pages. Page 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examiner was involved at once.

FOR
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA CROSS | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 25 87 | | 2b. HOUR 9:30 AM |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 07 07 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) COUNTY S.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE COUNTY CITY OR TOWN Md. Baltimore Turners | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13c. STREET ADDRESS / ZIP CODE 322 Solers Pt. Rd. 21222 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dave Williams | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Williams | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | 16b. SOCIAL SECURITY NO. 212-32-1942 | 17. INFORMANT ADDRESS Mrs. Nancie Crowley 628 N. Avondale | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) brain metastasis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO, OR AS A CONSEQUENCE OF (c) renal/adrenal carcinoma | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months unknown |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1 19 87 to 9/25 19 87 , that (I) (we) last saw the deceased alive on 9/25 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE F. McMahon | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 9/25/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. McMahon, MD | | 22e. ADDRESS FRANCIS SCOTT KEY Med Ctr | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | 9-28-87 | Arbutus | | Balto Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS James A Morton & Sons 1701 Laurens | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

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C.

Mr. F. H. Turner

Dave

No

Williams

Mr. H. H. Williams

Williams

Mr. H. H. Williams

Williams

M/A

David H. Williams

James A. Williams

065442 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|--|---|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE E. CROUSE Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 8, 1987 | | 2b. HOUR 9:30 A | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 27, 1915 | | |
| 6. AGE (IN YEARS (LAST BIRTHDAY)) 72 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8. CITIZEN OF WHAT COUNTRY? USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN U.S. FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE 1010 S. Ellwood Ave., 21224 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Elbert Crouse, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Julia Luedke | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | |
| 16b. SOCIAL SECURITY NO. 218-07-0766 | | 17. INFORMANT George E. Crouse 3rd | | ADDRESS 1904 Summit Ave. Balto. Md. 21237 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma of the Prostatic Gland</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 years</u> Approximate interval between onset and death: <u>5 minutes</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>87</u> , to <u>9/8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/8</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>Steven C. Marks</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/8/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven C. Marks, MD</u> | | 22e. ADDRESS <u>Johns Hopkins Hospital, Balto, MD</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | 23b. DATE <u>9/11/1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Security Process Inc. Catonsville, Balto. Md.</u> | | |
| 24. FUNERAL DIRECTOR NAME <u>McCully Funeral Homes Balto., Md. 21225</u> | | 24b. ADDRESS <u>237 E. Patapsco Ave.,</u> | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 14 1987</u> | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Julia A. [Signature]</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| CEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| Shirley | | 9 11 19 87 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| FEMALE | | BLACK | | MONTH DAY YEAR | |
| | | | | 10 21 28 | |
| 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | |
| 55 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| V.A. | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK) | |
| Baltimore | | 11 W. 20th Street | | HOUSEKEEPING | |
| 12b. KIND OF BUSINESS | | 13a. STATE | | 13b. COUNTY | |
| DISABLED | | MD | | BALTIMORE | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20 WEST 20th STREET 21218 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| LOVELACE | | UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 218-82-6585 | | ADDRESS | |
| | | | | OLA MANLEY 4445 LINTHICUM ROAD 21036 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cirrhosis | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | |
| (b) Chronic alcoholism | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Charles P. Kokes | | M.D. Assistant | | MEDICAL EXAMINER 9/11/87 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | Balto. MD | |
| Charles P. Kokes, M.D. | | 111 Penn St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 9/15/87 | | KING MEM. PK. CEMETERY | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| WM. C. MARCH F/H INC. | | 1101 E. NORTH AVENUE | | SEP 14 1987 | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | 25d. REGISTRAR'S SIGNATURE | |
| | | | | Julia Anderson-Rudolph | |

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SEP 14 01

1. The first part of the report is a general
 description of the project and its objectives.
 2. The second part is a detailed description of the
 methods used in the study.
 3. The third part is a description of the results
 of the study.
 4. The fourth part is a discussion of the results
 and their implications.
 5. The fifth part is a conclusion.
 6. The sixth part is a list of references.
 7. The seventh part is an appendix.
 8. The eighth part is a list of figures.
 9. The ninth part is a list of tables.
 10. The tenth part is a list of abbreviations.
 11. The eleventh part is a list of symbols.
 12. The twelfth part is a list of units.
 13. The thirteenth part is a list of definitions.
 14. The fourteenth part is a list of acronyms.
 15. The fifteenth part is a list of footnotes.
 16. The sixteenth part is a list of endnotes.
 17. The seventeenth part is a list of appendices.
 18. The eighteenth part is a list of figures.
 19. The nineteenth part is a list of tables.
 20. The twentieth part is a list of abbreviations.
 21. The twenty-first part is a list of symbols.
 22. The twenty-second part is a list of units.
 23. The twenty-third part is a list of definitions.
 24. The twenty-fourth part is a list of acronyms.
 25. The twenty-fifth part is a list of footnotes.
 26. The twenty-sixth part is a list of endnotes.
 27. The twenty-seventh part is a list of appendices.
 28. The twenty-eighth part is a list of figures.
 29. The twenty-ninth part is a list of tables.
 30. The thirtieth part is a list of abbreviations.
 31. The thirty-first part is a list of symbols.
 32. The thirty-second part is a list of units.
 33. The thirty-third part is a list of definitions.
 34. The thirty-fourth part is a list of acronyms.
 35. The thirty-fifth part is a list of footnotes.
 36. The thirty-sixth part is a list of endnotes.
 37. The thirty-seventh part is a list of appendices.
 38. The thirty-eighth part is a list of figures.
 39. The thirty-ninth part is a list of tables.
 40. The fortieth part is a list of abbreviations.
 41. The forty-first part is a list of symbols.
 42. The forty-second part is a list of units.
 43. The forty-third part is a list of definitions.
 44. The forty-fourth part is a list of acronyms.
 45. The forty-fifth part is a list of footnotes.
 46. The forty-sixth part is a list of endnotes.
 47. The forty-seventh part is a list of appendices.
 48. The forty-eighth part is a list of figures.
 49. The forty-ninth part is a list of tables.
 50. The fiftieth part is a list of abbreviations.
 51. The fifty-first part is a list of symbols.
 52. The fifty-second part is a list of units.
 53. The fifty-third part is a list of definitions.
 54. The fifty-fourth part is a list of acronyms.
 55. The fifty-fifth part is a list of footnotes.
 56. The fifty-sixth part is a list of endnotes.
 57. The fifty-seventh part is a list of appendices.
 58. The fifty-eighth part is a list of figures.
 59. The fifty-ninth part is a list of tables.
 60. The sixtieth part is a list of abbreviations.
 61. The sixty-first part is a list of symbols.
 62. The sixty-second part is a list of units.
 63. The sixty-third part is a list of definitions.
 64. The sixty-fourth part is a list of acronyms.
 65. The sixty-fifth part is a list of footnotes.
 66. The sixty-sixth part is a list of endnotes.
 67. The sixty-seventh part is a list of appendices.
 68. The sixty-eighth part is a list of figures.
 69. The sixty-ninth part is a list of tables.
 70. The seventieth part is a list of abbreviations.
 71. The seventy-first part is a list of symbols.
 72. The seventy-second part is a list of units.
 73. The seventy-third part is a list of definitions.
 74. The seventy-fourth part is a list of acronyms.
 75. The seventy-fifth part is a list of footnotes.
 76. The seventy-sixth part is a list of endnotes.
 77. The seventy-seventh part is a list of appendices.
 78. The seventy-eighth part is a list of figures.
 79. The seventy-ninth part is a list of tables.
 80. The eightieth part is a list of abbreviations.
 81. The eighty-first part is a list of symbols.
 82. The eighty-second part is a list of units.
 83. The eighty-third part is a list of definitions.
 84. The eighty-fourth part is a list of acronyms.
 85. The eighty-fifth part is a list of footnotes.
 86. The eighty-sixth part is a list of endnotes.
 87. The eighty-seventh part is a list of appendices.
 88. The eighty-eighth part is a list of figures.
 89. The eighty-ninth part is a list of tables.
 90. The ninetieth part is a list of abbreviations.
 91. The ninety-first part is a list of symbols.
 92. The ninety-second part is a list of units.
 93. The ninety-third part is a list of definitions.
 94. The ninety-fourth part is a list of acronyms.
 95. The ninety-fifth part is a list of footnotes.
 96. The ninety-sixth part is a list of endnotes.
 97. The ninety-seventh part is a list of appendices.
 98. The ninety-eighth part is a list of figures.
 99. The ninety-ninth part is a list of tables.
 100. The hundredth part is a list of abbreviations.

066921 SEP 28 87

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| DECEASED NAME (PRINT) EDDIE CUNNINGHAM JR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 23 87 | | 2b. HOUR 1435 M |
| 3 SEX male | 4. RACE black | 5. DATE OF BIRTH MONTH DAY YEAR 3 9 1931 | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALA | 7b. CITIZEN OF WHAT COUNTRY? U S A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY | 12b. KIND OF BUSINESS OR INDUSTRY Westinghouse | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3309 Powhatan Avenue 21216 | |
| 14. FATHER'S NAME Eddie | 15. MOTHER'S MAIDEN NAME Annie E. Elliston | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 377-26-3117 | 17. INFORMANT ADDRESS Naomi Cunningham 3309 Powhatan Avenue | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: b) <u>Unknown</u> DUE TO, OR AS A CONSEQUENCE OF c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Diabetes mellitus</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> 19 <u>87</u> to <u>9/23</u> 19 <u>87</u> that (II) (we) last saw the deceased alive on <u>8/12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | |
| 22b. SIGNATURE <u>Jef Zibell MD</u> | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 9/23/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jef Zibell</u> | 22e. ADDRESS <u>Union Memorial Hospital Baltimore MD</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/29/87 | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. c. March F/H West 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR SEP 25 1987 | 25b. REGISTRAR'S SIGNATURE <u>Julia Tindon-Padua</u> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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20% COTTON FIBRE

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067171 SEP 30 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|--|---|---|--|
| DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE DAILEY LAST | | 2a DATE OF DEATH MONTH DAY YEAR 9/23/87 2b HOUR 8:05 P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 9/18/18 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MEDICAL CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife |
| 12b. KIND OF BUSINESS OR INDUSTRY Domestic | | 12c. STREET ADDRESS / ZIP CODE 8412 Greenway Road, 21234 | |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anthony Parada | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO 217-26-0764 | |
| 17. INFORMANT Mrs. Joan G. Dailey Same as #13 | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>9/23</u> to <u>9/23</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) was (1) did not view the body after death. | | | |
| 22b. SIGNATURE Adlai L. Lillburne Pappay MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADLAI LILLBURNE PAPPAY | | 22e. ADDRESS Francis Scott Key Medical Center Baltimore, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/28/87 | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | 23d. LOCATION CITY OR TOWN COUNTY STATE glen Burnie, A.A. Md. |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Homes Balto., Md. 21225 | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1987 | |
| | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

25574

1- BASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Julia

M.

Damesyn

2a. DATE KNOWN ☒ OF ESTI- MONTH DAY YEAR 2b. HOUR
DEATH MATED ☐ 9/ 8/ 19 87 M

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE

MONTH DAY YEAR

2d. HOUR

Female

CAU.

4-12-13

74 YRS.

MONTHS DAYS HOURS MIN

2e. DATE

MONTH DAY YEAR

9/ 8/ 19 87

1:37 P M

7. BIRTHPLACE (STATE OR

COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK

OR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

Baltimore

4114 E. Northern Parkway

Homemaker

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. COUNTY

CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

27206

Maryland

Baltimore City

YES ☒ NO ☐

3602 E. Northern Hwy.

4. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Michael F. Ford

Barbara G. Raboe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

3208 Dudley Ave

No

(IF YES, GIVE WAR OR DATES)

219014541

Dolores A. Ford

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,

STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

Mario F. Golle, Jr.

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE
SIGNED

9/9/87

EXAMINER'S NAME
(TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

ADDRESS

111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

SEP 14 1987

Julia Tindem-Rudolph

25c. DATE REC'D. BY REGISTRAR

25d. REGISTRAR'S SIGNATURE

25e. DATE REC'D. BY REGISTRAR

25f. REGISTRAR'S SIGNATURE

25g. DATE REC'D. BY REGISTRAR

25h. REGISTRAR'S SIGNATURE

25i. DATE REC'D. BY REGISTRAR

25j. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A FUNERAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

082214 SEP 12 61



SEP 14 1961

064964 SEP 9 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25575

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruby Daniel | | | 2a. DATE OF DEATH MONTH DAY YEAR September 6, 1987 | | 2b. HOUR M |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 1 4 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lafayette Square Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1711 N. Bentalou St. 21216 |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-12-0984 | 17. INFORMANT ADDRESS Garnette Ballatt 2000 B Woodlawn Drive | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cerebral vascular</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>status post old CVA</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ulcerative colitis</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> 19 <u>87</u> to <u>Aug 6</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Aug 6</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | 22c. DATE SIGNED 9-7-87 |
| 22b. SIGNATURE <u>Franklin S. Addison MD</u> | | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Franklin S. Addison MD | | 22e. ADDRESS 924 W. North Ave. Balto. MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/9/87 | 23c. NAME OF CEMETERY OR CREMATORY Church Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Blackstone VA | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | ADDRESS 1101 E. North Avenue | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1987 | 25b. REGISTRAR'S SIGNATURE <u>Davidson-Penderson</u> |

BP

001001 200-001

065156 SEP 10 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25576

FOR
1. STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

James A Daniels

2a DATE OF DEATH MONTH DAY YEAR 9 7 87 2b HOUR 10:35AM

3. SEX (Black) Male

4. RACE Black

5. DATE OF BIRTH MONTH DAY YEAR 03 02 49

6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.

7b CITIZEN OF WHAT COUNTRY? U.S.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b KIND OF BUSINESS OR INDUSTRY

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE Md.

13b COUNTY

13c CITY OR TOWN Baltimore

13d INSIDE CITY LIMITS? YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE 1002 N. Fulton Ave. 21217

14. FATHER'S NAME FIRST MIDDLE LAST Eugene Daniels

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Reeves

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b SOCIAL SECURITY NO. 212-56-6879

17. INFORMANT ADDRESS Gwendolyn Daniels 831 N. Fulton Ave. 21217

18. CAUSE OF DEATH (Enter only one cause per line for (1), (2), and (3).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (1) Hepato-renal syndrome (2) Adult Resp. distress syndrome (3) acute Resp. failure and pneumonia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES ☐ NO ☒20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 8/17 19 87 to 9/7 19 87, that (I) (we) last saw the deceased alive on 8/17 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 9/7/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chas. A. Rice

22e. ADDRESS 1940 W. Baltimore St. Baltimore

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 9/12/87

23c. NAME OF CEMETERY OR CREMATORY Garrison Forest

23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md.

24. FUNERAL DIRECTOR

NAME Chas. A. Rice FSPA 1300 Eutaw Pl.

25a. DATE REC'D. BY REGISTRAR

SEP 9 1987

25b. REGISTRAR'S SIGNATURE

J. B. Borden

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Paper 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's report must be filed with this certificate.

062120 SEP 10 87

Gwendolyn Daniels 831 N. Fulton Ave. 2121

2/87

66883 SEP 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25577

FOR
1- STATE
REGISTRAR

| | | | | | | |
|---|---|--|---|--|--|--|
| DECEASED NAME (TYPE OR PRINT) BRADLEY WILLIAM DAUGHERTY | | | 2a DATE OF DEATH MONTH DAY YEAR SEPTEMBER 16, 1987 | | 2b HOUR 8:12 PM | |
| 3 SEX Male | 4 RACE Caucasian | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 16 1987 | | 6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 5 | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NIA | | 12b KIND OF BUSINESS OR INDUSTRY NIA | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md 13b COUNTY Howard 13c CITY OR TOWN Laurel | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 20 N. Carol St. 20707 | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST David Daugherty | | 15 MOTHER'S M maiden NAME FIRST MIDDLE LAST Kathy Roberts | | ADDRESS Same As Above | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT David Daugherty | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) renal dysplasia DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes 5 hours. | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT (IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I (this hospital) attended the deceased from 9-16 1987 to 9-16 1987 , that (I (we) last saw the deceased alive on 9-16 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did (did not) view the body after death. | | | | | | |
| 22b SIGNATURE Elizabeth C Engle | | DEGREE Attending Physician | | 22c DATE SIGNED 9-16-87 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Elizabeth C Engle | | 22e ADDRESS 600 N WOLFE ST BALTO MD 21205 Johns Hopkins Hosp Dept Pediatrics | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b DATE 9-18-87 | | 23c NAME OF CEMETERY OR CREMATORY Westview Mem. Park Catonsville COUNTY MD | | |
| 24 FUNERAL DIRECTOR NAME Donaldson Funeral Home P.A. | | ADDRESS Laurel, Md. | | 25a BY REGISTRAR 25b REGISTRAR'S SIGNATURE SEP 23 1987 John S. Sorenson-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate and the death certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 1 G-639
5/23/88 cm
067253 SEP 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|---|--|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Larry James Ross, Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 20 87 | | | | | 2b. HOUR 1:00 AM | | | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 19 87 | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 1 5 | | | IF UNDER 1 YEAR IF UNDER 24 HRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY Baltimore City | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 919 McKean Ave. 21217 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Larry James Ross, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORISUNK DAVIS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS unk | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-pulmonary failure DUE TO, OR AS A CONSEQUENCE OF (b) extreme prematurity DUE TO, OR AS A CONSEQUENCE OF (c) premature birth | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 65 minutes 65 minutes 65 minutes | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Paul J. Henrich MD | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/20/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul J. Henrich MD | | | | | | 22e. ADDRESS Mercy Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 9-24-87 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 24. FUNERAL DIRECTOR NAME State Anatomy Board | | | | | | ADDRESS Balto., Md. | | 25a. DATE RECEIVED BY REGISTRAR SEP 28 1987 | | 25b. REGISTRAR'S SIGNATURE John J. Henrich | | | |

081523 SEP 30 81

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25579

REG. NO.

FOR
1- BY REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

EUGENIA

LEE

DAVIS

1. SEX
F

4. RACE
B

5. DATE OF BIRTH
MONTH DAY YEAR
9 29 54

6. AGE (IN YEARS)
(LAST BIRTHDAY)
32 YRS.

IF UNDER 1 YR
MONTHS DAYS

IF UNDER 24 HRS.
HOURS MIN.

2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
9 21 87

2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9 21 87

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED
WIDOWED
NEVER MARRIED
DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
125 N. Colvin St.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A

12b. KIND OF BUSINESS OR INDUSTRY
N/A

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
MD

13b. COUNTY

13c. CITY OR TOWN
BALTO.

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS
125 COLVIN STREET 21202

14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY DAVIS

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JOSEPHINE WALKER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO

16b. SOCIAL SECURITY NO.
215-60-4500

17. INFORMANT
ADDRESS
JOSEPHINE DAVIS 6 E. READ STREET APT 504

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Narcotic Intoxication

DUPLICATE OF (a) AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUPLICATE OF (a) AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?
YES NO

21a. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 9-21 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject used drugs

21d. INJURY OCCURRED
WHILE NOT WHILE AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Home

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
125 N. Colvin St. Baltimore, MD

22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE

Ann M. Dixon

TITLE (SPECIFY)
M.D. Deputy Chief MEDICAL EXAMINER

DATE SIGNED 9-22-87

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL

23b. DATE
9/26/87

23c. NAME OF CEMETERY OR CREMATORY
MOUNT ZION CEMETERY

23d. LOCATION
CITY OR TOWN COUNTY STATE
LANDSDOWNE, MD

24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE

25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
SEP 25 1987 *Julia Anderson-Randall*

DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 701 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 701 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP 785

000000 200 20 00

2000 COTTON 10000

WASH-1000



064807 SEP - 4 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25580

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARIE DAVIS | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1, 1987 | | | 2b. HOUR 1:10^a M | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 8 2 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MARYLAND GENERAL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | | |
| 13a. STATE MD | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1412 W. SARATOGA STREET 21229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JESSIE TOMPKINS | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY CHAMBERS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-20-0372 | | 17. INFORMANT ADDRESS JESSIE TOMPKINS 1811 N. WOLFE STREET | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE SECONDARY TO TERMINAL CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) HYPOXEMIA, VENTILATOR DEPENDENT, OLIGURIA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from JULY 19, 1987 to SEPTEMBER 1, 1987 , that (X) (we) last saw the deceased alive on SEPTEMBER 1, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. ZUGHAYB | | | | 22e. ADDRESS c/o MARYLAND GENERAL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT CALVARY CEMETERY ANNE ARUNDEL CO., | | 23d. LOCATION CITY OR TOWN COUNTY STATE MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D BY REGISTRAR SEP 3 1987 | | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25581

067302

1. FOR
STATE
REGISTRAR2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE OF DEATH MONTH DAY YEAR

2b. HOUR

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS LAST BIRTHDAY)

7. UNDER 1 YEAR

8. UNDER 24 HRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

14. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (this hospital) attended the deceased from SEPTEMBER 11, 19 87, to SEPTEMBER 27, 19 87, that (we) last saw the deceased alive on SEPTEMBER 27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE RECEIVED BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

LEROY O. DYETT 4600 LIBERTY HEIGHTS

SEP 30 1987

Julia Davidson-Rodale

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

007302 101-101

065274 SEP 4 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25582

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PLATT DAVIS | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 05 87 | | 2b. HOUR 9:40 AM |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 05 04 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY Brick Layer |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Simon Davis | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Quick | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 242-26-6628 | | 17. INFORMANT ADDRESS Helen Davis 5003 Ivanhoe Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ESOPHAGEAL SQUAMOUS CELL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 SEVERE COPD | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/2/1987, to 9/5/1987, that (I) (we) (last) saw the deceased alive on 9/5/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE FADI BSAT | | | | 22c. DATE SIGNED 9/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FADI BSAT | | 22e. ADDRESS GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/11/87 | 23c. NAME OF CEMETERY OR CREMATORY BENNY CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BENNETTVILLE SC |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 09 1987 | | |
| ADDRESS 1101 E. NORTH AVENUE | | | | | |

MEDICAL CERTIFICATION

77
45
35
30
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

066294 SEP 19 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2503

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

TERIA LATRICA DAWKINS

1 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b HOUR

7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2d HOUR

FEMALE NEGRO

11-6-86

9 25

9-14-87 19

3:25a

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

10 CITY OR TOWN OF DEATH

Baltimore

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

University Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

BABY

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

13b COUNTY

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

13e STREET ADDRESS

14 FATHER'S NAME

RAYMOND DAWKINS

15 MOTHER'S MAIDEN NAME

STACEY K. CARTER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

NO

16b SOCIAL SECURITY NO.

17 INFORMANT

ADDRESS

21216

Mrs SAUNDRA CARTER 1105 N. DUKELAND ST

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocarditis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Margarita A. Korell, M.D.

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 9-14-87

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn Street

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION (CITY OR TOWN)

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

ADDRESS

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

JOSEPH L. RUSS 2221 W. NORTH AVE

SEP 18 1987

John Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, DIVISION OF VITAL RECORDS. EXAMINER, ALONG WITH FORM PM-1, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

DMHM - 17
(VR A15 ME (5))

0805000 25 19 07

066910 SEP 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25584

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIA DAWSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 23 87 | | 2b. HOUR 4 P M | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 8 5 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | |
| 12b. KIND OF BUSINESS OR INDUSTRY N/A | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE 704 E. 43rd STREET 21212 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | 15. MOTHER'S MAIDEN NAME FIRST LAST UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-18-3974D | | 17. INFORMANT ADDRESS ELAINE BRABHAN 5336 CORDELLIA AVENUE 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) UTI, INFLECTED DECUBITUS DUE TO, OR AS A CONSEQUENCE OF (c) LEUKOPENIA, STEROIDS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) EXTREME DEBILITATION | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-23 87 to 9-23 87 that (I) have lost saw the deceased live on 9-23 87 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Robert D. Matheson MD | | | | 22c. DATE SIGNED 9/23/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT D. MATHESON MD | | | | 22e. ADDRESS 5103 N. CHARLES ST BALTO 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE LANDOWNE MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR SEP 25 1987 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Benson-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Next please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examination should be indicated on item 18.

080010 SEP 29 61



066295 SEP 18

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25585

1. FOR
STATE
REGISTRAR

DECEASED NAME

FIRST
GRACEMIDDLE
W.LAST
DAY

2a. DATE OF DEATH

MONTH
SEPTEMBER 15, 1987DAY
5:11 A

3. SEX

female

4. RACE

black

5. DATE OF BIRTH

MONTH 6 DAY 1 YEAR 1914

6. AGE (IN YEARS LAST BIRTHDAY)

73

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Md

7b. CITIZEN OF WHAT COUNTRY?

U S A

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

THE JOHNS HOPKINS HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE) Retired

12b. KIND OF BUSINESS OR INDUSTRY

C & p Telephone

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

3322 Piedmont Avenue 21216

14. FATHER'S NAME

John

15. MOTHER'S MAIDEN NAME

Margaret

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

(YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO.

220-01-4182

17. INFORMANT

Peggy Franze

ADDRESS

3322 Piedmont Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Klebsiella pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Post-op complication

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Metastatic Ovarian Ca

19a. DATE OF OPERATION

8-19-87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Pelvic Mass R/O Ovarian Ca

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. N/A 19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

N/A

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

8-14

19-87, to

9-15

19-87, that (I) (we) last

saw the deceased alive on

Sept 15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Francine A. Olds, MD

DEGREE

MD

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

9-15-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Francine A. Olds, MD

22e. ADDRESS

600 N. Wolfe St Johns Hopkins Hosp Balt MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

9/18/87

23c. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

23d. LOCATION

CITY OR TOWN

Arbutus

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

Wm. C. March F/H West 4300 Wabash Avenue

25. DATE RECEIVED BY REGISTRAR

SEP 18 1987

25. REGISTRAR'S SIGNATURE

Julia Darden-Rudolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 19, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial/transit permit. There please remove confidential pages. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other trauma, or other trauma, the medical examiner should be notified of this.

000000 000000 000000



064871 SEP-8 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25586

REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) John Joseph Dececilio | | | 2a. DATE OF DEATH MONTH DAY YEAR September 02 87 | | 2b. HOUR M |
| 1. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 9 9 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH Glen Bernie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 341 WELLHAM AVENUE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY City Schools |
| 13a. STATE MD | | 13b. COUNTY BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 341 WELLHAM AVENUE 21061 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN DECECILIO | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA ARAUJO | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES ARMY | | 16b. SOCIAL SECURITY NO. 111-09-8806 | | 17. INFORMANT ADDRESS GWENDOLON DECECILIO 341 WELLHAM AVE 21061 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular event</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>End stage renal disease on chronic hemodialysis</u> | | | | | |
| 19a. DATE OF OPERATION <u>Sept 1 1987</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>PA 11/19 1987</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>7231 Ritchie Highway BALTIMORE MD</u> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1 1987</u> , to <u>Sept 1 1987</u> , that (II) (we) last saw the deceased alive on <u>Sept 1 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>S. Shabazz MD</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/3/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SHABAZZ MD</u> | | 22e. ADDRESS <u>7231 Ritchie Highway 21061</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 9/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMETERY | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | | 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVE. | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 4 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner shall be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, along with the death certificate, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

EX-100-932

EX-100-932

067454 OCT 2 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbon/copies. Page 1 will be filed with the health department 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25587

| | | | | | |
|---|---|---|--|--|---|
| 1. FOR - STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | P | |
| MARY E. DELANCEY | | SEPTEMBER 23, 1987 | | 7:00 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR June 1 1933 | 54 YRS. | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | Housewife | | --- |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. STREET ADDRESS / ZIP CODE | | |
| Maryland | | Port Deposit | 5 Cedar Dr., Woodlawn Est 21904 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | ADDRESS | |
| FIRST MIDDLE LAST Leonard F. Barrow | | FIRST MIDDLE LAST Ellen Hickman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | |
| No | | 215-30-6944 | David DeLancey | | |
| | | | Port Deposit, Md. 21904 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cervical CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>7 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16c. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/20/87</u> , 19 <u>87</u> , to <u>9/23/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/23/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE <u>McLellan</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/23/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>McLellan, Robert</u> | | 22e. ADDRESS <u>The Johns Hopkins Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | Sept 27, 1987 | West Nottingham Cem. | | Colora Cecil Maryland |
| 24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u> | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Lee A. Patterson & Son, Perryville, Maryland | | | OCT - 1 1987 | | <u>Julia Davidson-Roads</u> |

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067242 SEP 30 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25588
REG. NO.

| | | | | | | |
|---|--|---|--|--|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MICHAEL MIDDLE: Paul LAST: DELAUTER | | | 2a. DATE OF DEATH MONTH: SEPTEMBER DAY: 17, 1987 YEAR: 1987 | | 2b. HOUR 5:50 M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH: Nov. 20, 1965 DAY: 20 YEAR: 1965 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS, LAST BIRTHDAY) 21 IF UNDER 1 YEAR: MONTHS: 9, DAYS: 27 IF UNDER 24 HRS: HOURS: MIN. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Mt. Airy | | |
| 14. FATHER'S NAME FIRST: Paul MIDDLE: W. LAST: Delauter | | 15. MOTHER'S MAIDEN NAME FIRST: Jeanne MIDDLE: E. LAST: Plank | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-84-4134 | | 17. INFORMANT Paul W. Delauter, Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemodynamic instability</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fulminating Herpetic Hepatitis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>2 days</u> <u>3 days</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Hypostolemia; HYPOCALCEMIA</u> | | | | | | |
| 19a. DATE OF OPERATION 9/14/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Reversed Budd-Chiari Syndrome | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/14</u> , 19 <u>87</u> , to <u>9/17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>J. Malin</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/17/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MALIN</u> | | 22e. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u> <u>WASE ST.</u> <u>BALTO.</u> <u>MD 21205</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-20-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Locust Grove | | |
| 23d. LOCATION CITY OR TOWN Frederick | | COUNTY Md. | | STATE | | |
| 24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md. | | 25. DATE RECEIVED BY REGISTRAR SEP 24 1987 | | 26. REGISTRAR'S SIGNATURE <u>Julia Dindon-Rudner</u> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. That dealer remove carbonpapers, Pages 1 and 2 and send the card within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, medical examiner must be notified or called.

BP

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JANUARY 1952

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|--|----------|---------------|----|------|
| Paul | White | Nov. 20, 1942 | 21 | 0.75 |
| Maryland | U.S.A. | | | |
| Frederick M. Airt | | | | |
| Paul | Defector | | | |
| 212-84-412 Paul W. Defector, same as 18 | | | | |
| Paul | Defector | | | |
| Frederick M. | | | | |
| Charles A. Bortier, Jr., Specialist, 1st Lt. | | | | |
| Paul | | | | |

066015 SEP 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25589

REG. NO.

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice V. Delbarch</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9-14-87</i> | | 2b. HOUR <i>1:50 P.M.</i> |
| 3. SEX <i>Female</i> | 4. RACE <i>Black</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>4 13 25</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY)) <i>62</i> | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Va</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City MD.</i> | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Liberty Medical Center</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Disabled</i> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <i>Md</i> | | | 13b. COUNTY | 13c. CITY OR TOWN <i>Baltimore</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Washington</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dora Hutchinson</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | 16b. SOCIAL SECURITY NO. <i>213-204937</i> | | 17. INFORMANT ADDRESS <i>Mary Howard 6203 Edgewood Rd</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/14</i> , 19 <i>87</i> , to <i>9/14</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>9-14-</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Bach T Duong</i> | | DEGREE | | 22c. DATE SIGNED <i>9-14-87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BACH T DUONG</i> | | 22e. ADDRESS <i>LIBERTY MEDICAL CENTER.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>9/19/87</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Garrison Forest Vet</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Owings Mills Md</i> | |
| 24. FUNERAL DIRECTOR NAME <i>MARCH F/H 4300 WABASH AVE</i> | | 24a. DATE REC'D. BY REGISTRAR <i>SEP 17 1987</i> | | 24b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | |

MEDICAL CERTIFICATION

2

2

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages 1, 2, 3, and 4 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25590
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Please remove carbon papers. Page 3 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be filed with the State Dept. of Health and Mental Hygiene.

| | | | | | |
|--|-------------------------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) L Lovelist Dennis | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 9/10/87 | | 2b. HOUR 130am |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 12 9 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A./Sc. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. STREET ADDRESS / ZIP CODE 521 Willow Ave 21218 | |
| 14. FATHER'S NAME Julius Lovelist | | 15. MOTHER'S MAIDEN NAME Alice Williams | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 251-52-4707 | | 17. INFORMANT ADDRESS Hazel F. Lovelist 521 Willow Ave. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>metastatic Lung and Cancer Ca</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 6 months years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 10</u> , 19 <u>87</u> , to <u>Sept 10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Sept 10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Gene Kim MD | | | | 22c. DATE SIGNED 9/10/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gene Kim MD | | | | 22e. ADDRESS Union Memorial Hospital Balto Md 21218 | |
| 23a. BURIAL, CREMATION, REMOVAL (RECEIVED) BURIAL | | 23b. DATE 9-15-87 | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park Balto | |
| 24. FUNERAL DIRECTOR NAME Redd Funeral Home 5209 York Rd | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Dendron-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

52 DEPT F 81 X-415 3/1/81
 * * * * * A2N 22/1/81

EXAMINATION

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6. M. 1-12-81 1st section 1st wall
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065386 SEP 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25591

| | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--------------------------------------|--|--|---------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| ELIZABETH T. DERRICKS | | | | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | | 7. IF UNDER 1 YR. | | |
| F | | | B | | | 1 20 21 | | | 66 YRS. | | | IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. DATE PRONOUNCED DEAD | | |
| BALTIMORE MD | | | USA | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | BALTIMORE CITY | | | 9 8 19 87 | | |
| 11. CITY OR TOWN OF DEATH | | | 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 14. KIND OF BUSINESS OR INDUSTRY | | | 15. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Baltimore | | | 2005 Forest Heights Ave. | | | Domestic Purveyor | | | | | | BALTIMORE CITY | | |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 17. STATE | | | 18. COUNTY | | | 19. CITY OR TOWN | | | 20. STREET ADDRESS | | |
| MD | | | MD | | | BALTIMORE | | | 2005 Forest Heights Ave. | | | BALTIMORE CITY | | |
| 21. FATHER'S NAME | | | 22. MOTHER'S MAIDEN NAME | | | 23. INFORMANT | | | 24. ADDRESS | | | 25. DATE | | |
| FREDERICK GARNER | | | TERESA TURNER | | | BARBARA WONGUS | | | 3812 Gwynn Oak Ave. | | | 9-8-87 | | |
| 26. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 27. SOCIAL SECURITY NO. | | | 28. INFORMANT | | | 29. ADDRESS | | | 30. DATE | | |
| NO | | | 215-32-2809 | | | BARBARA WONGUS | | | 3812 Gwynn Oak Ave. | | | 9-8-87 | | |
| 31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | |
| 32. DATE OF OPERATION | | | | 33. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 34. AUTOPSY? | | | | | | |
| | | | | | | | | abdomen only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 35. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 36. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 37. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | |
| 38. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 39. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 40. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | | | | | |
| 41. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| 42. TITLE (SPECIFY) Deputy Chief | | | | | | | | | | | | | | |
| 43. DATE SIGNED 9-8-87 | | | | | | | | | | | | | | |
| 44. EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | | | | | | | | | |
| 45. ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | |
| 46. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 47. DATE | | | | 48. NAME OF CEMETERY OR CREMATORY | | | | | | |
| Burial | | | | 9. 12 87 | | | | New Cathedral | | | | | | |
| 49. FUNERAL DIRECTOR | | | | 50. DATE REC'D. BY REGISTRAR | | | | 51. REGISTRAR'S SIGNATURE | | | | | | |
| Marshall P. Hays | | | | SEP 10 1987 | | | | Julia Davidson-Randall | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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067400 OCT-1987

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|------------------------------|--|--|
| 1. DECEASED NAME (NAME OR PRINT) FIRST MIDDLE LAST Vincent Leo DeSantis, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR September 29, 1987 | | 2b. HOUR 12:30 P M | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR July 2, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bristol, Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Cen | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) business | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank DeSantis, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gallo | | 16. STREET ADDRESS / ZIP CODE 126 S. Highland Ave. 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW II 216-05-4161 | | 17. INFORMANT ADDRESS Frank DeSantis, 317 S. Conkling St. 21224 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 9, 1987</u> to <u>September 29, 1987</u> that (I) (we) lost saw the deceased alive or above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Victoria A. Vanik | | | | DEGREE MD | | 22c. DATE SIGNED 9/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VICTORIA A. VANIK | | | | 22e. ADDRESS 3411 BANK ST. Balt Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. Baltimore, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Joseph N. Zannino, 263 S. Conkling St. 21224 | | | | 25. DATE REC'D. BY REGISTRAR SEP 30 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

087400 OCT-1981

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1. The first part of the report deals with the general situation of the country and the progress of the work done during the year. It is a summary of the work done by the various departments and the progress of the work done by the various departments and the progress of the work done by the various departments.

2. The second part of the report deals with the results of the work done during the year. It is a summary of the results of the work done by the various departments and the progress of the work done by the various departments and the progress of the work done by the various departments.

3. The third part of the report deals with the conclusions of the work done during the year. It is a summary of the conclusions of the work done by the various departments and the progress of the work done by the various departments and the progress of the work done by the various departments.

4. The fourth part of the report deals with the recommendations of the work done during the year. It is a summary of the recommendations of the work done by the various departments and the progress of the work done by the various departments and the progress of the work done by the various departments.

5. The fifth part of the report deals with the conclusions of the work done during the year. It is a summary of the conclusions of the work done by the various departments and the progress of the work done by the various departments and the progress of the work done by the various departments.

067108 SEP 30 '87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column 18. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25593

REG. NO.

| | | | | | | | | |
|--|---|---|--|--|--|---|--|--|
| FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Guye Deshields | | | 09/21/87 | | | 8:50 PM | | |
| 3. SEX m | 4. RACE B 2 | 5. DATE OF BIRTH MONTH DAY YEAR 09/21/1900 | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Longshoreman | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE md | | | 13b. COUNTY City | | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PERRY A Dashiell | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth White | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-1529 | | | 17. INFORMANT ADDRESS Thomas G. Deshields 3201 Massachusetts Ave 21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electromechanical dissociation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Superior vena cava syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of unknown etiology</u> found on bronchoscopy biopsy (+) ~ 9/10/87 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 8/17/87 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Fibrosis Right Lung</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/17, 19 87, to 9/21, 19 87, that (1) we lost saw the deceased alive on 9/21, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) did not view the body after death. | | | | | | | | |
| 22b. SIGNATURE J. Petitto, M.D. | | | DEGREE | | | 22c. DATE SIGNED 9/21/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Petitto, M.D. |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/25/87 | | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md | | | 23e. DATE REC'D. BY REGISTRAR | | | 23f. REGISTRAR'S SIGNATURE SEP 29 1987 Julia Davidson-Randall | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue | | | | | | | | |

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SEP 30 1991

064968 SEP 1987

FOR
STATE
REGISTRAR

Irene H. DiAntonio

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Irene H. DiAntonio | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 8 87 | | | 2b. HOUR 2 55 AM | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3 13 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY - | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN FALLSTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 600 WESTBURY RD. 21047 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHESLAW KAZMIEROWSKI | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN SUSKA | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 220-03-8343 | | 17. INFORMANT ADDRESS SAME ADDRESS | | | | 17. INFORMANT ADDRESS SAME ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer of (L) Breast DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/27, 19 87, to 9/8, 19 87, that (I) (we) last saw the deceased alive on 9/8, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/8/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MELKON HAJINAZARIAN | | | | | | 22e. ADDRESS Good Samaritan Hosp. 14 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | | | |
| 24. FUNERAL HOME CHIMUNEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236 | | | | | | 25a. DATE REC'D BY REGISTRAR SEP 8 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, if medical examiner must be notified and a medical investigation must be conducted.

BP

084308 SEP-81

067160 SEP 30 1987

FOR Item 17, Film G632, 10-8-97

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|---|---|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Betty Jane Dickens | | | 2a. DATE OF DEATH MONTH DAY YEAR September 23, 1987 | | 2b. HOUR 3:35 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 10, 1932 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Carroll Co. | | 13c. CITY OR TOWN Reisterstown | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George C. Harris | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie F. Zombro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. NA | | 17. INFORMANT (Husband) Charles H. Dickens, Sr. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COMA WITH CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL CVA DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) END STAGE RENAL DISEASE | | | | | | |
| 9a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/22 1987 to 9/23 1987, that (I) (we) last saw the deceased alive on 9/22 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | |
| 22b. SIGNATURE JANE V. MORRIS, MD | | DEGREE | | 22c. DATE SIGNED 9/24/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JANE V. MORRIS, M.D. | | 22e. ADDRESS BON SECOUR HOSPITAL, BALTO. MD 21223 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sep 24, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Maryland | | | | | | |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home | | ADDRESS Glen Burnie, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1987 | | |
| | | 25b. REGISTRAR'S SIGNATURE Julia Tidwell-Randall | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Paper head 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified at once.)

00112 29 30 31

068172 OCT-987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 7 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE C. DIGGS | | | | | | | | | |
| 2a. DATE OF DEATH MONTH DAY YEAR 10 22 87 | | 2b. HOUR 8:46 P.M. | | 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 10 11 40 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 47 | | 7. UNDER 1 YEAR MONTHS DAYS 0 0 | | 8. UNDER 24 HRS. HOURS MIN. 0 0 | | 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD | | 10. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | 13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 13b. KIND OF BUSINESS OR INDUSTRY | | 14. CITY OR TOWN OF DEATH BALTIMORE | |
| 15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | 16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 17. STREET ADDRESS / ZIP CODE 2234 GUILFORD AVE 21218 | | 18. FATHER'S NAME FIRST MIDDLE LAST THOMAS WARREN | | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE YOUNG | | 20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 20b. SOCIAL SECURITY NO. 226-36-7726 | |
| 21. INFORMANT ADDRESS MR EDWARD DIGGS 2234 GUILFORD AVE 21228 | | 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Intravascular Coagulopathy DUE TO, OR AS A CONSEQUENCE OF (b) Unknown DUE TO, OR AS A CONSEQUENCE OF (c) Unknown | | 23. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: End Stage Renal Failure + GI bleeding | | 24a. DATE OF OPERATION | | 24b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 24c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 25d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 25e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 25f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 26. I certify that (I) (this hospital) attended the deceased from 9/30 , 19 87 , to 9/30 / 19 87 , that (I) (we) last saw the deceased alive on 9/30 / 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 27a. SIGNATURE Fahim Farhat MD DEGREE | |
| 27b. PHYSICIAN'S NAME (TYPE OR PRINT) Fahim Farhat, M.D. | | 27c. ADDRESS GOOD SAMARITAN HOSPITAL | | 27d. DATE SIGNED 9/30/87 | | 28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 28b. DATE 10/6/87 | |
| 28c. NAME OF CEMETERY OR CREMATORY King Mem. Pk. | | 28d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md. | | 29a. FUNERAL DIRECTOR NAME Joseph L. Russ | | 29b. ADDRESS 2222-26 W. North Av. | | 29c. DATE REC'D. BY REGISTRAR OCT 08 1987 | |
| 29d. REGISTRAR'S SIGNATURE Julia Borden-Pandey | | 29e. REGISTRAR'S SIGNATURE | | 29f. REGISTRAR'S SIGNATURE | | 29g. REGISTRAR'S SIGNATURE | | 29h. REGISTRAR'S SIGNATURE | |

BP

008175 OCT-087

BALTIMORE CITY

HALLIMORE SCHOOL PATRIOTIC WAR HOSPITAL

MD

FORWARD TO THE

FOR STAPLER RECORDS

FEDERAL BUREAU OF INVESTIGATION

OCT 08 1917

067297 OCT 11 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Carrie Diggs | | 2a. DATE OF DEATH MONTH DAY YEAR 9 23 87 | | 2b. HOUR 10³⁵ PM | |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH DAY MONTH YEAR 11 09 98 | 6. AGE (IN YEARS LAST BIRTHDAY) 88 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union M Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 5610 York Road 21212 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Otto Luckan | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Weskey | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | |
| 16a. SOCIAL SECURITY NO. 212-22-3413 | | 17. INFORMANT Marie D. Green Baltimore, MD 21207 | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 87 , to 9/23 , 19 87 , that (I) (we) last saw the deceased alive on 9/23 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE S. Oresky | DEGREE MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 9/23/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Oresky | | 22e. ADDRESS Union Memorial Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE 09/25/87 | 23c. NAME OF CEMETERY OR CREMATORY Security Process | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balto. MD | 24. FUNERAL DIRECTOR NAME ADDRESS 299 Frederick Road, Balto. MD Cremation Society of MD 21228 | |
| 25a. DATE REC'D. BY REGISTRAR SEP 30 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

067297 OCT-1-87

Ballston City

Ballston Hospital

Ballston



Ballston Hospital

SEP 30 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FRONTIS FRONTIS | | MIDDLE | | DIGGS, JR. DIGGS JR | | 20. DATE OF DEATH MONTH DAY YEAR September 16, 1987 SEPT. 16, 1987 | | 20. HOUR 1:50 P.M. | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH JULY 4, 1928 JULY 7, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | | | |
| 10. CITY OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MEDICAL CENTER | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY No. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE 1052 Luzerne Avenue 21205 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frontis Diggs, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 245-28-8898 | | 17. INFORMANT ADDRESS Josephine Diggs 1052 Luzerne Ave. 21205 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 31</u> , 19 <u>87</u> , to <u>Sept 16</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Sept 16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>R. Desmarais MD.</u> | | | | | | DEGREE | | 22c. DATE SIGNED <u>9-16-87</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. L. DESMARAIS</u> | | | | | | 22e. ADDRESS <u>FRANCIS SCOTT KEY MED CTR BALT MD.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-22-87 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR Marshall W. Jones, Jr F.H. 4101 Edmondson Ave | | | | | | 21229 | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Parker-Randall</u> | | | |

MEDICAL CERTIFICATION

100530 SEP 19 81

7

2-55-0

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25599

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

REDESSA

D.

DIGGS

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b. HOUR
ESTIMATED ☐ 9-24-87 19 M

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE

MONTH DAY YEAR

2d. HOUR

FEMALE

BLACK

3 27 63

24 YRS.

MONTHS

DAYS

HOURS

MIN.

PRONOUNCED DEAD

9-24-87 19

5:43a

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒ NEVER MARRIED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MARYLAND

U. S. A.

WIDOWED ☐ DIVORCED ☐

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Baltimore

4843 Truesdale Avenue

KEY PUNCH OPERATOR

12b. KIND OF BUSINESS

AGENCY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

MARYLAND

BALTIMORE

YES ☒ NO ☐

4843 TRUESDALE AVE. 21206

14. FATHER'S NAME

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

AN FORD

MOORE

MARGARET

CALOWELL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

16b. SOCIAL SECURITY NO.

17. INFORMANT

NO

214-88-6390

MR. BALTIMORE, MD. 21218

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot wound of chest

DUPLICATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUPLICATE CAUSE (b)

DUPLICATE CAUSE (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
5:25a 9-24-87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
self/inflicted

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
bedroom 2nd fl.

21f. LOCATION
4843 Truesdale Avenue
CITY OR TOWN Baltimore, COUNTY Maryland, STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Dennis F. Smyth, M.D.

(TITLE - SURETY)

Assistant MEDICAL EXAMINER

DATE SIGNED 9-24-87

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN

COUNTY

STATE

BURIAL

9/28/87

GARRISON FORES VET. CEM.

BALTIMORE, MD.

24. FUNERAL HOME

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

2501 GWYNNS FALLS PKWY. BALTO. MD. 21218

SEP 28 1987

John D. ...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

067531 299 001

289 85 932

064970 SEP-98

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

Agnes F. DiMattei

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME FIRST MIDDLE LAST Agnes Dimattei | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 05 87 | | | | 2b. HOUR 1235 M | | | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 4-5-1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 72 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 204 E. Kingston Park La. 21220 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jacob Pokorny | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Hrach | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | |
| 16b. SOCIAL SECURITY NO. 213-05-2239 | | | | 17. INFORMANT Agnes Hartman | | | | ADDRESS 158 N. Curley St. 21224 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARYTHMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Berna Nappal | | | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. NAPPAL | | | | | | | | 22e. ADDRESS 100 N. BROADWAY | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-8-87 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page, with carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 38 shows late injury, or other traumatic event, the medical examiner must be available at once.

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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066490 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2560

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|---|--|--|---|--|---|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) William H. Disney | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9/ 20/ 19 87 | | | 2b. HOUR M | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 3 1929 | | 6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9/ 20/ 19 87 | | 2d. HOUR 11:33 A M | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2749 Hawkins Point Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | | | 12b. KIND OF BUSINESS OR INDUSTRY Trucking | | | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY A.A. | | | | 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS 175 Carvel Beach Road 21226 | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elmer R. Disney | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Mauler | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | | | 16b. SOCIAL SECURITY NO. 1946-1950 | | | | | | 17. INFORMANT Diana L. Wilson 331 Stafford Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell, M.D. | | | | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 9/21/87 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | | | | | 23b. DATE 9/24/87 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1987 | | | | | | 25b. REGISTRAR'S SIGNATURE John D. ... | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP
DHMH - 17
(VR A15 ME (5))

028120 SEP 23 91

SEP 23 1991

067232 SEP 30 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

2- DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
FLORA ISABELLE DIXON

2a DATE OF DEATH MONTH DAY YEAR
9 22 87

2b HOUR
6²⁰ AM

3 SEX
FEMALE

4 RACE
BLACK

5. DATE OF BIRTH
MONTH DAY YEAR
5 29 92

6 AGE (IN YEARS LAST BIRTHDAY)
95

IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS.

7a BIRTHPLACE (STATE OR FOREIGN)
MARYLAND

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8 MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE MD.

10 CITY OR TOWN OF DEATH
BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Inns of Evergreen Central

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEKEEPER

12b KIND OF BUSINESS OR
INDUSTRY
PVT. FAMILY

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
MARYLAND

13b COUNTY
BALTIMORE

13c CITY OR TOWN
BALTIMORE
YES ☒ NO ☐

13d STREET ADDRESS / ZIP CODE
140 W. Lafayette Ave. 21207

14 FATHER'S NAME
FIRST MIDDLE LAST
JOHN H. DIXON

15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA GRAY

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO

16b SOCIAL SECURITY NO.
220-30-0734A

17 INFORMANT ADDRESS
BALTO, MD.
METROPOLITAN U.M. CHURCH 1121 W. LANVALE ST.

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) COPD

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

CARDIAC ARRYTHMIA; PNEUMONIA / Renal FAILURE.

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION
STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 9-13-87, to 9-22-87 that (I) (we) lost
saw the deceased alive on 9-13-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING
PHYSICIAN

MEDICAL
DIRECTOR

STAFF
PHYSICIAN

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

Yomi FAKUNLE

2300 GARRISON BLVD BALTIMORE 21207

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION
CITY OR TOWN COUNTY STATE

BURIAL

9/26/1987

MD. NATIONAL MEM. PK.

LAUREL, MARYLAND

24 FUNERAL HOME

NUTTER FUNERAL HOMES, INC.
2501 GWYNN FALLS PKWY, BALTIMORE, MD. 21216

25a DATE REC'D. BY REGISTRAR
SEP 28 1987

25b REGISTRAR'S SIGNATURE
John Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

067235 SEP 20 61

50% COTTON FIBER

SEP 28 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

John J. Dobbs, Jr.

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

7a. DATE KNOWN
OF ESTI
DEATH MATED

MONTH DAY YEAR

7b. HOUR

Male

Cauc.

6/28/36

51 YRS.

MONTHS

DAYS

HOURS

MIN

7c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR

7d. HOUR

8. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Maryland

USA

Baltimore City

MD

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS
OR INDUSTRY

Baltimore

Fayette and Greene Street

Truck Driver

Food Store

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

Maryland

--

Baltimore

xx

3714 Lyndale Ave, 21213

14. FATHER'S NAME

John J. Dobbs, Sr.

15. MOTHER'S MAIDEN NAME

Dorothy Thompson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

NO

--

219-30-4958

Victoria Dobbs, Wife, same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

P.M. 19

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE ☒ NOT WHILE ☐
AT WORK AT WORK

22a. I certify that I took charge of the remains described above, held an

Autopsy ☒

Inspection ☐

Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☒

Accident ☐

Suicide ☐

Homicide ☐

Undetermined manner ☐

ACTUAL
SIGNATURE

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 9-7-87

EXAMINER'S NAME
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn Street, Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

Burial

9/9/87

Parkwood Cemetery

Balto., Md.

24. FUNERAL DIRECTOR
NAME

3331 Brehms Lane

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

SCHIMUNEK FUNERAL HOME, Balto., Md. 21213

SEP 8 1987

a Gordon-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (1))

004002 200-301

UNION

MAINTAIN



9345 10700 8002

067402 OCT -

187 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25607

| | | | | | | |
|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Elsie E Dorsey | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/26/87 | | 2b. HOUR 10:03 PM | |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 12/07/24 | 6. AGE (IN YEARS LAST BIRTHDAY) 62 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of MD Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 308 N. Mount St 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hezekiah Johnson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Poole | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-18-6676 | 17. INFORMANT ADDRESS Hatonya Strong 21223 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arrhythmias DUE TO, OR AS A CONSEQUENCE OF (c) Possible Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Diabetes Mellitus, Old Myocardial Infarction | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25/87 , 19 87 , to 9/26 , 19 87 , that (I) (we) last saw the deceased alive on 9/26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death. | | | | | | |
| 22b. SIGNATURE S. Dellon MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/26/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Dellon MD | | | | 22e. ADDRESS 72 S. Greene St, Baltimore, MD 21201 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-2-87 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md. |
| 24. FUNERAL DIRECTOR NAME Jas. A. Morton & Sons 1701 Laurens | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

066559 SEP 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25605
REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PATRICIA GRACE DRAKE | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 18 1987 | | 2b. HOUR M 11 |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR OCT. 12 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CLEVELAND, OHIO | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH PARKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7605 DANIELS AVE, BALTO. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTO. CO. | 13c. CITY OR TOWN PARKVILLE | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROLAND MITCHELL | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN OZAK | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 285-30396 | | 17. INFORMANT ADDRESS FAMILY RECORDS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of LUNGS ? DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-4 , 19 86 , to 9-11 , 19 87 , that (I) (we) last saw the deceased alive on 9-11 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DR. GHILADI | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GHILADI | | | | 22e. ADDRESS 7600 OSLER DRIVE TOWSON | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-21-1987 | 23c. NAME OF CEMETERY OR CREMATORY EBELAWN MEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE CLEVELAND OHIO |
| 24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIES, PARKVILLE | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1987 | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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20275

RECEIVED AT 20275

DICTIONARY

100-100000

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100-100000

20275

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT Lee DROCELLA | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 8 87 | | | 2b. HOUR 6 ⁰⁰ P.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 13 33 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHOP SAW OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY Sun Place. In | |
| 13a. STATE MARYLAND | | 13b. COUNTY ----- | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE S E. HEATH ST. Balto. Md. 21230 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK Robert DROCELLA | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ----- HEATH | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea | | 17. INFORMANT Doris Heck, Same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTIC SHOCK - PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>METASTATIC SQUAMOUS LUNG CANCER</u> 3 MONTHS | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/8/87</u> 19 <u>87</u> to <u>9/18</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/8</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert Feingold | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT FEINGOLD | | | | | | 22e. ADDRESS 3001 S. HANOVER ST. BALTO, MD. 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/12/1987 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemt. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. A.A. Co. Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These three pages are carbon copies. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

08244 SEP 12 01

SEP 4 1901

065858 SEP 16 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25607

Freda M. Dromelhausen

| | | | | | | |
|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Freda M Dromelhausen | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 / 13 / 87 | | 2b. HOUR 8 ²⁰ A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 19 1897 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY | | 10. CITY OR TOWN OF DEATH BALTIMORE | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY at home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Martin J. Reese | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine A. Pfrom | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 212-52-9366 | | 17. INFORMANT ADDRESS James Mann Suite 600 409 Washington Ave 21204 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic arthritis of the @ shoulder.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>UTI</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Congestive Heart Failure - Metabolic (electrolytes) disturbances</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> 19 <u>87</u> to <u>9/13</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>A. Maalov</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/13/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASSAAD MAALOV | | 22e. ADDRESS GOOD SAMARITAN HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-16-1987 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. 5305 Harford Rd. | | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

082828 259 12 87

067097 SEP 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25608

REG. NO.

| | | | | | |
|---|-------------------------|---|---|---|-----------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPHINE M. DROZD | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 25 87 | | 2b. HOUR 12:55 AM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 16 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY — | | 13a. STREET ADDRESS / ZIP CODE 1814 E. BANK ST. - 21231 | |
| 13b. STATE MARYLAND | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE DUDEK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BARANOWSKI | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 213-01-3285 | | 17. INFORMANT MILDRED PASEK | | ADDRESS 2605 KENTUCKY AVE, 21213 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATED PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 10 WEEKS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 25 87 P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 9/23 19 87 to 9/25 19 87 , that (I) (we) lost saw the deceased alive on 9/25 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Donna L.P. Phillips, MD | | DEGREE MD | | 22c. DATE SIGNED 9/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONNA L.P. PHILLIPS, MD | | 22e. ADDRESS 301 ST PAUL PL BAL MD 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/28/87 | | 23c. NAME OF CEMETERY OR CREMATORY ST STANISLAUS CEM. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | | 24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zaleski Inc. 1901 Eastern Ave | | | |
| 25. DATE REC'D. BY REGISTRAR SEP 28 1987 | | 26. REGISTRAR'S SIGNATURE Julia Schmitt-Rudner | | | |

087007 SEP 23 81

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25609

FOR
1- STATE
REGISTRAR

REG NO

| | | | | | | |
|---|---|--|---|---|---|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Rush Duncan | | | 2a DATE OF DEATH MONTH DAY YEAR Sept. 14, 1987 | | 2b HOUR 09 14 87 | |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR January 26, 1911 | | 6 AGE (IN YEARS (LAST BIRTHDAY)) 76 | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ashe County North Carolina | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lineman | | 12b KIND OF BUSINESS OR INDUSTRY Gas & Elect. Utility | |
| 13a STATE Maryland | | 13b COUNTY Harford Co. | 13c CITY OR TOWN White Hall (21161) | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE 4229 Norrisville Road 21161 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Arthur Munro Duncan | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Ellen Absher | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b SOCIAL SECURITY NO. 213-01-3491 | | 17 INFORMANT (NAME) ADDRESS Mrs. Mary A. Duncan 4229 Norrisville Road White Hall Maryland 21161 | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years yrs | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 COPD | | | | | | |
| 19a DATE OF OPERATION NA | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED NA | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) NA | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE NA | | |
| 22a I certify that (I) (this hospital) attended the deceased from Aug 25 , 19 87 , to Sept 14 , 19 87 , that (I) (we) last saw the deceased alive on Sept 14 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE Cara L. Davis | | | | DEGREE MD | | 22c DATE SIGNED 9/14/87 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Cara L. Davis M.D. | | | | 22e ADDRESS 201 E. University Parkway Baltimore. | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE Sept. 16, 1987 | | 23c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | | 23d LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014 |
| 24 FUNERAL DIRECTOR Joseph William Foster 50 W. Broadway & Williams St. Bel Air, Maryland 21014 | | | | 25a DATE RECD. BY REGISTRAR SEP 15 1987 | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy of the report filed with this certificate.

FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FANNIE E DUNSTON | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-29-87 | | 2b. HOUR 2:45^PM |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 10 20 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2311 Reisterstown Road 21217 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alvin Hayes | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cherry | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 218-18-0922 | | 17. INFORMANT Naomi Joyner ADDRESS 2311 Reisterstown Rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUDDEN DEATH. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) No Leprosy. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia. Adrenal Insufficiency. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/26 , 19 87 , to 9/29 , 19 87 that (I) (we) lost saw the deceased alive on 9/29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Bich T Duong | | DEGREE M.D. | | 22c. DATE SIGNED 9-29-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG | | 22e. ADDRESS LIBERTY MEDICAL CENTER. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/3/87 | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallston Md |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H West | | ADDRESS 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1987 | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25611

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|--|--|---|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST Jean Alberta Durkan | | | MONTH DAY YEAR 9 3 87 | | | 5:00 PM | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 2 05 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed | | |
| 12b. KIND OF BUSINESS OR INDUSTRY Unknown | | | 13a. STREET ADDRESS / ZIP CODE 10 Stevens Rd. / 21061 | | | | | |
| 13b. CITY OR TOWN Balto. | | | 13c. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Konstanty Rynciewicz Bronislawa | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luhawska | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO. 215091759 | | | 17. INFORMANT Edward J. Rynciewicz | | |
| | | | ADDRESS 1251 Delbert Ave. Dundalk Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Myelogenous Leukemia</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0. | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/27</u> 19 <u>87</u> , to <u>9/3</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>9/3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Cheng Wai-Fung</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>9/3/87</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHENG, WAI-FUNG</u> | | | | | | 22e. ADDRESS <u>South Baltimore General Hosp.</u> <u>3001 S. Hanover St., Balto. MD 21230</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | | 23b. DATE <u>Sept. 4, 1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, City Maryland</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Walter Brooks Bradley F.H. Inc. Dundalk, MD. 21222</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 08 1987</u> | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please prepare a death certificate. Pages 1 and 2 should be filed within 92 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.

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1 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: <i>Rose</i> MIDDLE: <i>Pauline</i> LAST: <i>Earl</i> | | | 2a. DATE OF DEATH MONTH: <i>September</i> DAY: <i>3</i> YEAR: <i>1987</i> | | 2b. HOUR <i>12:55 PM</i> |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH: <i>9</i> DAY: <i>26</i> YEAR: <i>27</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i> YRS. MONTHS: <i></i> DAYS: <i></i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Key Medical Center</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housework</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE <i>Md.</i> | 13b. COUNTY <i>Baltimore</i> | 13c. CITY OR TOWN <i>Eastwood</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <i>7230 Gough Street 21224</i> | |
| 14. FATHER'S NAME FIRST: <i>Robert</i> MIDDLE: <i></i> LAST: <i>Lowe</i> | | 15. MOTHER'S MAIDEN NAME FIRST: <i>Elizabeth</i> MIDDLE: <i></i> LAST: <i></i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>213-28-3740</i> | | 17. INFORMANT ADDRESS: <i>George T. Earl 7230 Gough Street 21224</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>DIABETES MELLITUS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8/16</i> P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) <i>John</i> hospital attended the deceased from <i>8/16</i> 19 <i>87</i> , to <i>8/6</i> 19 <i>87</i> , that (I) examined saw the deceased alive on <i>8/16</i> 19 <i>87</i> , and that in my <i>my</i> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Robert Fisher</i> | | DEGREE <i>MD.</i> | | 22c. DATE SIGNED <i>8/3/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT FISHER M.D.</i> | | 22e. ADDRESS <i>6918 RIDGE RD. BALTO, MD. 21237</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>9-5-87</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eastwood Balto. Co., Md.</i> |
| 24. FUNERAL DIRECTOR NAME: <i>Charles S. Zeiler & Son Inc.</i> ADDRESS: <i>6224 Eastern Ave.</i> | | | 25. DATE REC'D. BY REGISTRAR <i>SEP 03 1987</i> 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please include subpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25613

| | | | | | | |
|---|--|--|---|--|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Miriam Coffay Easley | | | 2a. DATE OF DEATH MONTH DAY YEAR 9. 12 87 | | 2b. HOUR 9:20 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 6, 1910 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 12. CITY OR TOWN OF DEATH Baltimore City | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 14. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | 16. 13b. COUNTY --- | | 17. 13c. CITY OR TOWN Baltimore | | |
| 18. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 19. 13e. STREET ADDRESS / ZIP CODE 114 E. Melrose Ave. 21212 | | 20. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | |
| 21. 12b. KIND OF BUSINESS OR INDUSTRY ---- | | 22. 4. FATHER'S NAME FIRST MIDDLE LAST John Patrick Coffay | | 23. 5. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Kelly | | |
| 24. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 25. 16b. SOCIAL SECURITY NO. 212-03-6142 | | 26. 17. INFORMANT ADDRESS Henry Easley 114 E. Melrose Ave. 21212 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>LUL tumor (type unknown)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD / cigarette abuse / HTN / CVA</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>87</u> , to <u>9/12</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>Donna Dow</u> | | DEGREE | | 22c. DATE SIGNED <u>9/12/87</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donna Dow | | 22e. ADDRESS Union Memorial Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-15-87 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville, Baltimore, Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Road 21212 | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | | |

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1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE KHELM EDWARDS | | | 7a. DATE OF DEATH MONTH DAY YEAR September 24, 1987 | | 7b. HOUR 2:35p M |
| 3 SEX Female | 4. RACE White | 5. DATE OF BIRTH May 14, 1897 | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian-Hamilton Nursing Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3609 Glenmore Ave. 21206 |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Dobson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Mooney | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. 217-34-4200D | 17. INFORMANT ADDRESS Ruth M. Clift, 2421 Hillford Dr. 21234 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure due to metastasis in lungs</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Caregiver of uterus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>inoperable with widespread metastasis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>5/7</u> , 19 <u>85</u> to <u>9/24</u> , 19 <u>87</u> that (I) <u>we</u> last saw the deceased alive on <u>9/20</u> , 19 <u>87</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <u>did not</u> view the body after death. | | | | | |
| 22b. SIGNATURE <u>I. W. Fromm</u> | | DEGREE | | 22c. DATE SIGNED Sept. 25, 1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) I. W. Fromm, M.D. | | 22e. ADDRESS 80I4 Old Harford Rd. Balto. MD 21234 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 28, 1987 | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. |
| 24. FUNERAL DIRECTOR NAME ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214 | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 | | |
| | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified by police.

BP

000000 22 05 19

• 31 •

65021 SEP-9-87

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25015
25615
2a DATE OF DEATH MONTH DAY YEAR 9 5 1987 2b HOUR 12:45mDECEASED NAME
(TYPE OR PRINT)

MILKIN

MIDDLE

LAST

EDWARDS

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

MONTH DAY YEAR
1 / 16 / 42

6. AGE (IN YEARS LAST BIRTHDAY)

44

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS

HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

South Carolina

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

University of Maryland Hosp

12a. USUAL OCCUPATION

Unemployed

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

1045 W. Lanvale 21217

14. FATHER'S NAME

MILTON

MIDDLE

LAST

EDWARDS

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

LAST

EDWARDS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

N/A

17. INFORMANT

249-68-5189

ADDRESS

Sarah Edwards 1045 W. Lanvale

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Small cell lung cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last

saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING

MEDICAL

STAFF

PHYSICIAN ☐ DIRECTOR ☐ PHYSICIAN ☒

22c. DATE SIGNED

9/5/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Thomas Sweet, M.D.

22e. ADDRESS

22 S. Greene St. Balto, MD 21209

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY) Burial

23b. DATE

9-11-87

23c. NAME OF CEMETERY OR CREMATORY

Eastview Cemetery

23d. LOCATION

Baltimore

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

NAME

Leroy O. Dyett & Son

ADDRESS

4600 Liberty

Hghts. Avenue

25a. DATE REC'D. BY REGISTRAR

SEP 08 1987

25b. REGISTRAR'S SIGNATURE

John Darden

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

82031 SEP-80

110M 413E

SEP 08 1980

066108 SEP 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25016
25616

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LAWRENCE Raymond Elick | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 16 87 | | | 2b. HOUR 6:57 AM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven VA Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | | 12b. KIND OF BUSINESS OR INDUSTRY Self | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 27 S. Castle St. 21231 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Henry Elick | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Bryant | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT ADDRESS Joyce V. Jeffords, 3946 Schroeder Ave. 21128 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPOTENSION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE HEART FAILURE</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>HOURS</u> <u>YEARS</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>RONAL FAILURE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Donald L. Kinsler</u> DEGREE | | | | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD L. Kinsler | | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept. 19, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, Md. | | | |
| 24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL Home Inc. 6009 Harford Rd., Balto. Md. 21214 | | | | | | 25a. DATE RECD. BY REGISTRAR SEP 17 1987 | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

000108 SEP 18 81

DECEMBER

1981

065112 SEP 10 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|--|--|---|---|----------------------------------|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERIC ELLIS | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 2, 1987 | | 2b. HOUR MIN. 10:00 | | | | | | | | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 8 12 1940 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 47 | | IF UNDER 1 YEAR MONTHS DAYS 0 0 | | IF UNDER 24 HRS. HOURS MIN. 0 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3402 Keston Road 21207 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederic William Ellis | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda Commodore | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes | | | | | | 16b. SOCIAL SECURITY NO. 212-36-8833 | | 17. INFORMANT ADDRESS Janice Ellis 3402 Keston Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT VENTRICULAR FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) BLEEDING (c) AORTIC VALVE REPLACEMENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 5 hrs 7 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: H/O BACTERIAL ENDOCARDITIS + IV DRUG ABUSE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9-2-87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC INSUFFICIENCY | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-25 , 19 87 , to 9-2 , 19 87 that (I) (we) last saw the deceased alive on 9-2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Shumway MD | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9-2-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHUMWAY | | | | | | 22e. ADDRESS 618 Blalock Bldg Johns Hopkins Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 09 1987 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

RELEASED AS NON-MED. DR. GOLLE PER MR. FURVIS

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be signed by the attending physician and filed in the hospital or attending physician's files. It should be detached for use as the burial permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in the hospital or attending physician's files, it should be detached for use as the burial permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked as "not applicable," the medical examiner's report must be filed with the certificate.

002112 SEP 10 87

EXHIBIT 100

100-100

EXHIBIT 100

EXHIBIT 100

066107 SEP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25618

1. STATE
GISTRAR

Ellwood Edwin Emkey

2. DECEASED NAME
(TYPE OR PRINT)

ELLWOOD

FIRST

MIDDLE

LAST

Emkey

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
9/16/87 7 30 A
M3. SEX
Male4. RACE
White5. DATE OF BIRTH
Feb. 27, 19236. AGE (IN YEARS (LAST BIRTHDAY))
64IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY)
Baltimore, Md.7b. CITIZEN OF WHAT COUNTRY?
USA8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD.10. CITY OR TOWN OF DEATH
BALTIMORE11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
FRANCIS SCOTT KEY MEDICAL CENTER12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Attendant12b. KIND OF BUSINESS OR
INDUSTRY
Gas Station13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Maryland13c. CITY OR TOWN
Baltimore13d. INSIDE CITY LIMITS?
YES ☐ NO ☒13e. STREET ADDRESS / ZIP CODE
6 Barnacle Court 2122114. FATHER'S NAME
FIRST MIDDLE LAST
August C. Emkey15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Myrtle Wilson16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII16b. SOCIAL SECURITY NO.
218 12 445717. INFORMANT
ADDRESS
Clayton E. Emkey, Son Baltimore, Md. 2122218. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

CARDIO-PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) END-STAGE LUNG CA

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from 9/15 19 87 to 9/16 19 87, that (I) (we) last
saw the deceased alive on 9/15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

9/16/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR

24a. ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Przydzinski Funeral Home PA 1407 Old Eastern Ave. 21221 SEP 17 1987 in Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

000101 932 701220

066552 SEP 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20. DATE OF DEATH MONTH DAY YEAR
SEPTEMBER 17, 1987
20. HOUR P M
11:501. DECEASED NAME
(TYPE OR PRINT)FIRST
JOHNMIDDLE
E.LAST
ENDERS3. SEX
MALE4. RACE
WHITE5. DATE OF BIRTH
MONTH DAY YEAR
AUG. 08, 19456. AGE (IN YEARS LAST BIRTHDAY)
42IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.IF UNDER 24 HRS
HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY)
OHIO7b. CITIZEN OF WHAT COUNTRY?
U.S.A.8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD.10. CITY OR TOWN OF DEATH
BALTIMORE11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ACCOUNTANT12b. KIND OF BUSINESS OR
INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
MARYLAND13b. COUNTY
BALTO. CO.13c. CITY OR TOWN
PARKVILLE13d. INSIDE CITY LIMITS?
YES ☐ NO ☒13e. STREET ADDRESS, ZIP CODE
9109 OLD HARFORD RD. 2123414. FATHER'S NAME
FIRST MIDDLE LAST
JOHN J. ENDERS15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
WILMA M. EISWEIRTH16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO16b. SOCIAL SECURITY NO.
213-46-012017. INFORMANT
- FAMILY RECORDS -18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 wks

Conditions, if any, which
gave rise to immediate
cause (b), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Dilatation Cardiomyopathy

3 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c) Sarcoidosis

3 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?
YES ☒ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATEWHILE AT WORK ☐ NOT WHILE AT WORK ☐

22a. I certify that (1) (this hospital) attended the deceased from 9/19, 1987, to 9/17, 1987, that (1) (w) last saw the deceased alive on 11:30 9/17, 1987, and that in (1) (w) apian death occurred on the date and hour and from the causes stated above, (1) (w) (did not) view the body after death.

27b. SIGNATURE
Alton V. Hallum MD

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐27c. DATE SIGNED
9/18/8727d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALTON V. Hallum MD22e. ADDRESS
Johns Hopkins23a. BURIAL CREMATION, REMOVAL
(CHECK)
BURIAL23b. DATE
09-21-198723c. NAME OF CEMETERY OR CREMATORY
PARKWOOD CEM.23d. LOCATION
CITY OR TOWN COUNTY STATE
PARKVILLE BALTO. CO. MD24. FUNERAL DIRECTOR
NAME ADDRESS
EVANS CHAPEL OF MEMORIES25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
SEP 22 1987 John Davidson

000225 SEP 23 83

1 5 50 115 8
3 NOV 25 1983
4 1101 24 100 100

20% COTTON

SEP 23 1983

067001 SEP 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25620

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JEFFREY T. ENGWALL | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 24, 1987 | | 2b. HOUR 2:44P M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR April 14, 1984 | | 6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependent | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3407 Parkside Drive 21214 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas L. Engwall | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane D. Dillon | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-06-8085 | | 17. INFORMANT ADDRESS Thomas L. Engwall 3407 Parkside Dr. 21214 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOTENSION</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>RESPIRATORY FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u> <u>2 DAYS</u> <u>2 MONTHS</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONGENITAL HEART DISEASE</u> | | | | | |
| 19a. DATE OF OPERATION <u>6/24/87</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CONGENITAL HEART DISEASE</u> | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (if this hospital attended the deceased from <u>9/24</u> to <u>9/24</u> 19 <u>87</u> , that (if not) last saw the deceased alive on <u>9/24</u> 19 <u>87</u> , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Peter Hornepper</u> | | DEGREE <u>M.D.</u> | | 22c. DATE SIGNED <u>9/24/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PETER HORNEPPER</u> | | 22e. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sep 28 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR ***** Leonard J. Ruck, Inc. Baltimore, Maryland | | 25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 28 1987 <u>John Davidson-Randall</u> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director must completely fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 3 and 4, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

067 00 1 00 730

20-26 015-2611-10111111

066351 SEP 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|---|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth C. Erisman | | | 2a. DATE OF DEATH MONTH DAY YEAR September 20, 1987 | | 2b. HOUR 3:01 a.m. | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 13, 1892 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Inn of The Evergreen Nursing Home | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Joppatown | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ambrose Wirth | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Lichty | | 13d. STREET ADDRESS / ZIP CODE Joppatown, Md. 301 Barks Dale Road 21085 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-07-5493 | | 17. INFORMANT 21085 ADDRESS Joppatown, Md. Dorothea E. Bauer 301 Barks Dale Rd. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiovascular Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH — | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Recurrent Urinary Tract Infection</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the undersigned) attended the deceased from <u>11/26/82</u> to <u>9/20/87</u> , that (I) (we) last saw the deceased alive on <u>9/10/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>Albert B. Bradley</u> | | DEGREE M.D. | | 22c. DATE SIGNED 9/21/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Albert B. Bradley M.D. | | 22e. ADDRESS 4900 Belair Road Baltimore, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sep 22 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | | |
| 24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. | | ADDRESS Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1987 | | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u> | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then place in envelope and return to the State Dept. of Health and Mental Hygiene prior to burial. A statement of removal is required.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and appear.

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20-10-18

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REGISTRAR

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|-----------------|--------------------|---|--|---|--|---|---------------|------------------|--|---|--|--|-----------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Frederick | | | MIDDLE Evans | | | LAST Evans | | | 2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9/ 8/ 19 87 | | | 2b. HOUR M 6:25 PM | | | | |
| 3 SEX MALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 8 16 48 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 39 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9/ 8/ 19 87 | | | 2d. HOUR M 6:25 PM | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED | | | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | |
| 13a. STATE MD | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN BALTIMORE | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 905 N. MONROE STREET 21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM A. SMITH | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAE EVANS | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | | 16b. SOCIAL SECURITY NO. 213-52-3631 | | | | | | 17. INFORMANT ADDRESS MAE OWENS 905 N. MONROE STREET 21217 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia Suppurative Submandibular Infection</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Fatty Liver</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i> | | | | | | TITLE (SPECIFY) Assistant M.D. | | | | | | DATE SIGNED 9/9/87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. | | | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | 23b. DATE 9/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY MOUNT AUBURN CEMETERY | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | | | | | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. | | | | | | ADDRESS 1101 E. NORTH AVE. | | | | | | 25a. DATE REC'D BY REGISTRAR SEP 10 1987 | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Julia Swinson-Randall</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25M

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DHMH - 17
(VR A15 ME (5))

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QW08



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Irene Elizabeth Evans | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 10 87 | | | 2b. HOUR M | | | | |
| 3. SEX Female | | 4. RACE BLK | | 5. DATE OF BIRTH MONTH DAY YEAR 9 25 26 | | 6. AGE [IN YEARS LAST BIRTHDAY] 61 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4022 N. Rodger Ave | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4022 N. Rodger Ave. 21207 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Tinsley | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hicks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 215-242645 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Endometrial Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-9-86</u> to <u>9-9-87</u> , that (I) (we) last saw the deceased alive on <u>9-9-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | | | DEGREE MD | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeff Miller | | | | | | 22e. ADDRESS 1634 N. Broadway | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9-14-87 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD | | | |
| 24. FUNERAL DIRECTOR NAME Jeff Miller F.H. | | | | | | 25a. DATE REC'D BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudace | | |

MEDICAL CERTIFICATION

2
9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21207

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WATKINS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|--|--|-----------------------------------|
| DECEASED NAME (TYPE OR PRINT) FIRST <u>Jimmy</u> MIDDLE <u>Connelly</u> LAST <u>Evans</u> | | 2a. DATE OF DEATH MONTH <u>9</u> DAY <u>25</u> YEAR <u>87</u> | | 2b. HOUR <u>5⁴⁵A</u> M | |
| 3 SEX <u>Male</u> | 4 RACE <u>White</u> | 5. DATE OF BIRTH MONTH <u>2</u> DAY <u>22</u> YEAR <u>35</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>52</u> YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u> | 7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City,</u> MD. | |
| 10 CITY OR TOWN OF DEATH <u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Francis Scott Key Med Ctr.</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Stationary Engineer/Engineering</u> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>N/A</u> | 13c. CITY OR TOWN <u>Baltimore</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST <u>Themis</u> MIDDLE <u>T.</u> LAST <u>Evans, Sr.</u> | | 15 MOTHER'S MAIDEN NAME FIRST <u>Sally</u> MIDDLE <u>Mae</u> LAST <u>Wallace</u> | | 13e. STREET ADDRESS / ZIP CODE <u>38 Seaford Ave. / 24221 21221</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>Yes</u> | | 16b. SOCIAL SECURITY NO. <u>227-40-1293</u> | | 17 INFORMANT (brother) <u>Aubrey L. Evans</u> ADDRESS <u>521 Old North Point Road Baltimore, MD 24221</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>87</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/24</u> , 19 <u>87</u> , to <u>9/25</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>9/25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>My [Signature]</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>9/25/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M Finger hood</u> | | 22e. ADDRESS <u>Francis Scott Key Med Ctr 4940 Eastern Ave Balt.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>Sept. 28, 1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Temple Hill Cemetery, Castlewood, VA</u> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR <u>OCT 01 1987</u> | | | |
| 24 FUNERAL DIRECTOR NAME <u>Capitol Funeral Service, Falls Church, VA</u> | | 24b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | | | |

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Austin L. Everett | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/15/87 | | 2b. HOUR 4:35 AM | |
| 3. SEX M | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 8 43 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U of MD Hosp | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY Tischer Auto Parts Inc. | | | | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST (Tommy) Austin Everett | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona Everett | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 579 56 8116 | | 17. INFORMANT ADDRESS Dorothy J. Everett 2106 Chelsea Terrace | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-9 , 19 87 , to 9-15 , 19 87 , that (I) (we) last saw the deceased alive on 9-15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Sung W. Lee MD | | DEGREE MD | | 22c. DATE SIGNED 9/15/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUNG LEE | | 22e. ADDRESS 22 S. Greene St, Balt, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD | | 24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Ave | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>John Thomas R...</i> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS Jory EWING | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 29, 1987 | | 2b. HOUR 1:05A M |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 15, 1941 | | 6 AGE (IN YEARS LAST BIRTHDAY) 46 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurant & Motel Owner | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Q.A. | 13c. CITY OR TOWN Chester | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Thomas Raymond Ewing | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jory | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-42-7306 | | 17 INFORMANT ADDRESS Kay N. Ewing same as above | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic derangement</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>terminal pancreatic cancer</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 2 weeks 1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 14</u> 19 <u>87</u> , to <u>Sept 29</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Sept 29</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE <u>Mark S. Schmitzer</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/29/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK S. SCHMITZER, MD | | 22e. ADDRESS JH H | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/01/87 | | 23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Stevensville Q.A. MD | | 23e. DATE REC'D BY REGISTRAR OCT 02 1987 | | | |
| 24 FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Chester, MD 21619 | | 25. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, please attach a medical examiner's report to this certificate.

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SECRET 1000002 9

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SECRET 1000002 9

065974 SEP 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Gertrude A. Fagan | | 2a. DATE OF DEATH MONTH DAY YEAR September 12, 1987 | | 2b. HOUR 4:51 PM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 8, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOUSE) Francis Scott Key Medical Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland | | 12b. COUNTY Baltimore | | 12c. CITY OR TOWN Baltimore | |
| 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS / ZIP CODE 1708 Malvern St. 21224 | | 13c. STREET ADDRESS / ZIP CODE 1708 Malvern St. 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar Dickens | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Mattie Stevenson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | |
| 16b. SOCIAL SECURITY NO. 240-03-7102 | | 17. INFORMANT Helen Quade | | 17. ADDRESS 1708 Malvern St. 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atrial Fibrillation</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 26</u> , 19 <u>87</u> , to <u>Sept. 12</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Sept 12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE C Packard MD | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/12/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cairy A. Packard MD | | 22e. ADDRESS Francis Scott Key Med Ctr; Baltimore, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (OR STATE) | | 23b. DATE 9-15-98 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | |
| 23d. LOCATION (CITY OR TOWN) COUNTY STATE Baltimore M.D. | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE SEP 16 1987 Julia Davidson-Randall | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222 | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

062074 SEP 17 83



SEP 16 1983

066531 SEP 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | |
|--|--|---|---|--|--|--|
| 2. DECEASED NAME (TYPE OR PRINT) Stella E. FARACE | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/20/87 | | 2b. HOUR 8:55 P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 01 - 03 - 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levindale Nsg Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Randallstown | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 8622 DOVEDALE ROAD 21133 | | |
| FATHER'S NAME FIRST MIDDLE LAST Henry Shaw | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Shaw | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 214-18-7666 | | 17. INFORMANT ADDRESS Joseph Farace 8622 Dovedale Rd. MD 21133 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a LIVER METASTASIS, BRAIN METASTASIS - FROM @ ABOVE | | | | | | |
| 19a. DATE OF OPERATION — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-3 , 19 87 , to 9-20 , 19 87 , that (I) (we) lost saw the deceased alive on 9-20 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE MD | | | 22c. DATE SIGNED 9-21-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.J. Lucco | | 22e. ADDRESS 2434 W. BELWESURE AVE. BALTIMORE 21215-5299 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9-23-87 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD | | |
| 24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc ADDRESS 8728 Liberty Rd. Randallstown, MD 21133 | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it will be filed in the funeral director's file. This should be detached for use as the burial-transit permit. This permit, together with the death certificate, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, please only injury, or other traumatic event, is medical examiner must be notified at once.

000001 000000

RECEIVED FOR THE

U.S. DEPARTMENT OF

THE TREASURY

WASHINGTON, D.C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | |
|--|---------|------------------|------------------------------|--|---------------------|---|--|--|---------------------------|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF DEATH | | | 2c. DATE OF DEATH | | | 2d. DATE OF DEATH | | |
| Dorothy M. Faulhaber | | | 9 10 19 87 | | | 9 10 19 87 | | | 9 10 19 87 | | | 7:38 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | |
| Female | White | 7 21 1926 | 61 YRS. | | | Baltimore City | | | Baltimore | | | Francis Scott Key Medical Center | | |
| 12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 13. CITIZEN OF WHAT COUNTRY? | | | 14. MARRIED | | | 15. WIDOWED | | | 16. DIVORCED | | |
| Maryland | | | USA | | | NEVER MARRIED | | | | | | | | |
| 17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 18. STATE | | | 19. COUNTY | | | 20. CITY OR TOWN | | | 21. INSIDE CITY LIMITS? | | |
| Housewife | | | Maryland | | | Baltimore | | | Dundalk | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 22. STREET ADDRESS | | | 23. MOTHER'S MAIDEN NAME | | | 24. ADDRESS | | | 25. STREET ADDRESS | | | 26. CITY OR TOWN | | |
| 7538 Westfield Road 21222 | | | Mable | | | Andrew E. Faulhaber 7538 Westfield Road | | | 7538 Westfield Road | | | 21222 | | |
| 27. FATHER'S NAME | | | 28. MOTHER'S NAME | | | 29. ADDRESS | | | 30. STREET ADDRESS | | | 31. CITY OR TOWN | | |
| Charles | | | Schisler | | | Mable | | | 7538 Westfield Road | | | 21222 | | |
| 32. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 33. SOCIAL SECURITY NO. | | | 34. INFORMANT | | | 35. ADDRESS | | | 36. STREET ADDRESS | | |
| No | | | 212-22-6478 | | | Andrew E. Faulhaber | | | 7538 Westfield Road | | | 21222 | | |
| 37. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma of colon with metastases | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | |
| 38. DATE OF OPERATION | | | | 39. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 40. AUTOPSY? | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 41. EXTERNAL CAUSE WAS | | | | 42. TIME OF INJURY | | | | 43. HOW INJURY OCCURRED | | | | | | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | HOUR A.M. MONTH DAY YEAR | | | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | |
| 44. INJURY OCCURRED | | | | 45. PLACE OF INJURY | | | | 46. LOCATION | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | STREET, FACTORY, FARM, ETC.) | | | | CITY OR TOWN COUNTY STATE | | | | | | |
| 47. I certify that I have charge of the remains described above, held on death resulted from | | | | | | | | | | | | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| 48. TITLE (SPECIFY) | | | | | | | | | | | | | | |
| M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | |
| 49. DATE SIGNED 9/11/87 | | | | | | | | | | | | | | |
| 50. EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St. Balto.MD. | | | | | | | | | | | | | | |
| 51. BURIAL, CREMATION, REMOVAL | | | | 52. DATE | | | | 53. NAME OF CEMETERY OR CREMATORY | | | | 54. LOCATION | | |
| Burial | | | | 9-14-87 | | | | Holly Hill | | | | Baltimore Maryland | | |
| 55. FUNERAL DIRECTOR | | | | 56. DATE REC'D. BY REGISTRAR | | | | 57. REGISTRAR'S SIGNATURE | | | | | | |
| NAME Duda-Ruck Funeral Home of Dundalk | | | | SEP 15 1987 | | | | Julia Davidson-Randall | | | | | | |
| ADDRESS 7922 Wise Ave. Dundalk, MD 21222 | | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

02871 SEP 18 07

066647 SEP 24 87

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25630

| | | | | | | | |
|--|-----------------|--|--|---|---|---|-----------------------------------|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert T. Faulkner | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9-19-1987 | | | 2b. HOUR M 9:00 | |
| 3 SEX male | 4 RACE black | 5 DATE OF BIRTH MONTH DAY YEAR 12 18 1953 | 6 AGE (IN YEARS) (LAST BIRTHDAY) 33 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-19-1987 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H. Braxton | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys M. Faulkner | | 13e. STREET ADDRESS 3923 Park Heights Avenue 21215 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-64-5310 | | 17. INFORMANT ADDRESS Rosalind McGill 3510 Lucille Avenue | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Fatty liver

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Alcoholism

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i> | | TITLE (SPECIFY) Assistant | | MEDICAL EXAMINER DATE SIGNED 9-20-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., MD | | ADDRESS 111 Penn St., Baltimore, MD 21201 | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia T. ...</i> | |

DIVISION OF VITAL RECORDS, 201 W. BOSTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BOSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

000000 2 SEP 68

066900 SEP 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25631

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Lucy J Featherstone</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>9 21 87</u> | | 2b. HOUR <u>1205 PM</u> |
| 3. SEX <u>FEMALE</u> | 4. RACE <u>Black</u> | 5. DATE OF BIRTH MONTH DAY YEAR <u>08 22 10</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 74 HRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>VA</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balt City</u> MD | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Univ of MD Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <u>Retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> | | 13b. COUNTY <u>Balt</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <u>2405 Middle St #1213</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Jeff Randolph</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE <u>Sarah Hamlett</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. <u>224-20-1210</u> | | 17. INFORMANT ADDRESS <u>Lessie Walker 1634 Wolfe Street</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis - Fungemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis - Enterococcus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>One week</u> <u>3 wks</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Brain Stem CVA</u> | | | | | |
| 19a. DATE OF OPERATION <u>8/14/87</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hydrocephalus</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased <u>9/21/87</u> am <u>9/21/87</u> to <u>9/21/87</u> that (I) (we) last saw the deceased alive on <u>9/21/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John Ragheb</u> | | | | 22c. DATE SIGNED <u>9/21/87</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>9/26/87</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>WOODLAWN MD</u> |
| 24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H</u> | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 25 1987</u> | | |
| ADDRESS <u>1101 E. North Ave.</u> | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Tindon-Randall</u> | | |

MEDICAL CERTIFICATION

9/21/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25632

| | | | | | | | | | | | | | | |
|--|---------|------------------|--|-------------------|---------------------|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF ESTI- MATED | | | 2c. DATE PRONOUNCED DEAD | | | 2d. DATE OF DEATH | | |
| Delores Lou Fee | | | 9 10 1987 | | | 9 10 1987 | | | 9 10 1987 | | | 2:07 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | |
| Female | White | Nov. 17, 29 | 57 | | | Baltimore City | | | Baltimore | | | 5100 Blk. Falls Rd | | |
| 12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 13. CITIZEN OF WHAT COUNTRY? | | | 14. MARRIED | | | 15. NEVER MARRIED | | | 16. DIVORCED | | |
| Pennsylvania | | | U.S.A. | | | WIDOWED | | | NEVER MARRIED | | | DIVORCED | | |
| 17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 18. STATE | | | 19. COUNTY | | | 20. CITY OR TOWN | | | 21. INSIDE CITY LIMITS? | | |
| Baltimore | | | Md. | | | - | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 22. STREET ADDRESS | | | 23. FATHER'S NAME | | | 24. MOTHER'S MAIDEN NAME | | | 25. INFORMANT | | | 26. ADDRESS | | |
| 1912 Sulgrave Ave 21209 | | | Flick | | | Lucy Guthrie | | | Leo B. Fee, SR. | | | | | |
| 27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 28. PART I DEATH WAS CAUSED BY: | | | 29. IMMEDIATE CAUSE (a) | | | 30. DUE TO, OR AS A CONSEQUENCE OF | | | 31. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 8147 | | | Multiple injuries | | | | | | | | | | | |
| 32. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | 33. DATE OF OPERATION | | | 34. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 35. AUTOPSY? | | | 36. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 37. 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 38. 21b. TIME OF INJURY | | | 39. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | | 40. 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 41. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | |
| Pedestrian struck by auto | | | 1:40 P.M. 9 10 1987 | | | Pedestrian struck by auto | | | 5100 Blk. Falls Rd, Balto. | | | MD | | |
| 42. 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from | | | 43. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 44. ACTUAL SIGNATURE | | | 45. TITLE (SPECIFY) | | | 46. DATE SIGNED | | |
| Charles P. Kokes, M.D. | | | Assistant | | | 9/11/87 | | | | | | | | |
| 47. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 48. 23b. DATE | | | 49. 23c. NAME OF CEMETERY OR CREMATORY | | | 50. 23d. LOCATION | | | 51. 23e. COUNTY | | |
| Cremation | | | 9-14-1987 | | | Westview Crematory | | | Winters Lane, Baltimore 21228 | | | BALTO. | | |
| 52. 24. FUNERAL DIRECTOR | | | 53. 25a. DATE REC'D. BY REGISTRAR | | | 54. 25b. REGISTRAR'S SIGNATURE | | | 55. 25c. DATE REC'D. BY REGISTRAR | | | 56. 25d. REGISTRAR'S SIGNATURE | | |
| Burgee-Henss Funeral Home, Baltimore, Md. | | | SEP 17 1987 | | | Davidson-Randall | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH CERTIFICATE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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064834 SEP-8 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25633

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jennie M. FEFEL | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 2 87 | | | 2b. HOUR 1:15 AM | | | | |
| 3. SEX F | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 1 89 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 98 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY --- | | |
| 13a. STATE Maryland | | | 13b. COUNTY --- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1917 W. Lombard Street, 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph M. Julie | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Bowman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- | | 17. INFORMANT Edward J. Smardon, 307 S. Bentalou Street | | ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/23</u> , 19 <u>87</u> , to <u>9/1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. David J. ...</u> | | | | | | DEGREE | | 22c. DATE SIGNED 9/1/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. DAVID J. ... | | | | | | 22e. ADDRESS ST AGNES HOSP BALTIMORE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/5/87 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 04 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julie Davidson</u> | | |

MEDICAL CERTIFICATION

35
30
300
1987
9/1/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

064834 SEP-87

SEP04 1987

066280 SEP 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--------|---|--|--|--|--|--|---|--|--------------------------|--|--------------|--|--------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| James | | Ferrell | | | | | | 9 | | 16 | | 19 | | 87 | | M | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | 2c. HOUR | |
| M | B | 6 23 12 05 | | 82 5 YRS. | | | | | | 9 | | 16 | | 19 | | 87 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED | | NEVER MARRIED | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| VA | | USA | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | MD | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 525 Cherry Hill Road | | AMERICA COPPER | | RETIRED | | | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | | | | | | | |
| MD | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 525 CHERRY HILL ROAD 21225 | | | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | |
| UNKNOWN | | UNKNOWN | | UNKNOWN | | UNKNOWN | | UNKNOWN | | UNKNOWN | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 214-16-3935A | | ANNIE FERRELL | | 525 CHERRY HILL RD. 21225 | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Shotgun wound of thorax & abdomen | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? | | BODY ONLY | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 6:45xx 9 16 1987 | | Self inflicted | | WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | home | | 525 Cherry Hill Rd, | | Baltimore | | | | MD. | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | Deputy Chief | | | | 9/16/87 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | BALTO. MD. | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| BURIAL | | 9/21/87 | | MARYLAND NAT'L MEM. PK. | | LAUREL | | | | | | | | | | MD | |
| 24 FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE | | SEP 18 1987 | | Lisa Davidson-Randall | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25633

| | | | | | | |
|--|--|--|---|--|---------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE BARBARA FIEHN | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 21, 1987 | | 2b. HOUR 10:40A _M | |
| 3. SEX Female | | 4. RACE Caucasion | | 5. DATE OF BIRTH MONTH DAY YEAR 4 - 30 - 17 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN. IF UNDER 24 HRS: HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Glen Burnie | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 102 Furnlea Drive/21061 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Buttner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Badum | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 127-09-6624 | | 17. INFORMANT 877 Doris Drive Robert Fiehn Arnold, MD 21012 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malignant Ascites</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Transitional Cell Cancer of Bladder 1 month</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coronary Artery Disease</u> | | | | | | |
| 19a. DATE OF OPERATION 8/24/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Urinary Diversion - Ileal Loop | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/18</u> , 19 <u>87</u> , to <u>9/21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>M. Borland</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/24/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Borland | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-23-87 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A., MD | | | | | | |
| 24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO SEVERNA PARK, MD. 21146 | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25050

REG. NO.

| | | | | | | | |
|---|--|--|--|---|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GWENDOLYN FIELDS | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-6-87 | | 2b. HOUR 3:25 PM | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 8 4 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN 67 | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) Bon Secours | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE 13a. STATE MD | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST W. Herbert Hillend | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Johnson | | 16a. SOCIAL SECURITY NO. 220-12-7700 | | 17. INFORMANT ADDRESS FALLS PKWY 21216 | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No. | | 18b. SOCIAL SECURITY NO. 220-12-7700 | | 18c. INFORMANT ADDRESS GERALDINE FIELDS 3333 GWYNNS | | 18d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Quiescent Adenocarcinoma Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Insulin Dependent Diabetes Mellitus, ASCVD | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Insulin Dependent Diabetes Mellitus, ASCVD | | | | | | | |
| 19a. DATE OF OPERATION 8-11-87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Quiescent Adenocarcinoma | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MD | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) ON SEPTEMBER 4 1987 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ON SEPTEMBER 4 1987 | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | 22a. I certify that (I) (this hospital) attended the deceased from ON SEPTEMBER 4 1987 to SEP 10 1987 that (I) (we) last saw the deceased alive on SEP 10 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | |
| 22a. SIGNATURE Mark Levine | | 22b. DEGREE MD | | 22c. DATE SIGNED SEP 10 1987 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK LEVINE | |
| 22e. ADDRESS Bon Secours | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/11/1987 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | 24. FUNERAL DIRECTOR NAME ADDRESS NUITER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTO. MD. 21216 | | 25a. DATE REC'D BY REGISTRAR SEP 10 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 5 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2b. DATE OF DEATH | | MONTH DAY YEAR | | 2c. HOUR | |
| | | KXX FILIPPOS K. FILIPPOU | | | | SEPTEMBER 28, 1987 | | | | 6:26P _M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 1 HRS | |
| Male | | White | | MONTH DAY YEAR 5 4 13 | | 74 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Greece | | U.S.A. | | | | Baltimore City | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | Church Hospital | | Teacher | | School | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 525 N. Luzerne Avenue 21205 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST Kallistos Filippou | | FIRST MIDDLE LAST Maria | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | 244-42-3418 | | Mrs. Marianthi Filippou | | 525 N. Luzerne Ave. Baltimore, Md. 21205 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF <u>CEREBROVASCULAR ACCIDENT</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 10</u> , 19 <u>87</u> , to <u>SEPT. 28</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | | 22c. DATE SIGNED | | | |
| <u>Beena Nappal</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 9/28/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| BEENA NAPPAL | | CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 10-1-87 | | Oak Lawn Cemetery | | Baltimore Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Anr S. Matthews, Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224 | | | | | | OCT 01 1987 | | <u>David R. Radcliffe</u> | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RUTH ILSE FINCH | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 23, 1987 | | 2b. HOUR 5:17 P.M. | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 25, 1919 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 67 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2135 BOLTON STREET 21217 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MARTIN SCHUSTER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH HABELHOHN | | 13e. STREET ADDRESS / ZIP CODE 2135 BOLTON STREET 21217 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-52-3834 | | 17. INFORMANT ADDRESS STEVEN L. FINCH 2135 BOLTON ST. 21217 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of ovary</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>Hospice</u> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Sept 11 87</u> <u>Sept 23 87</u> | | | |
| 22a. I certify that <u>we</u> (this hospital) attended the deceased from <u>Sept 11 87</u> to <u>Sept 23 87</u> , that <u>we</u> (we) lost saw the deceased alive on <u>Sept 22 87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> (did) (did not) view the body after death. | | | | 22b. SIGNATURE <u>W.B. Daniels, Jr.</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W.B. Daniels, Jr.</u> | | 22d. ADDRESS <u>Union Memorial Hospice Baltimore 21218</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (BURIAL) | | 23b. DATE 9/23/87 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VETERANS CEM-OWINGS MILLS BALTO MD | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1987 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Devison-Randall</u> | | | |

MEDICAL CERTIFICATION

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SEP 24 1963

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 25037

| | | | | | | |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SHARON RACHAEL FINK | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 16, 1987 | | 2b. HOUR 4:25 P.M. | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 28, 1955 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY LAZARUS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EUNICE SCHWEITZER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-52-2784 | | 17. INFORMANT STUART M. FINK 7423 RICKSWAY RD. BALTO., MD 21207 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multi-system failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer (lymphoma)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 1 wk. 9 mos. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 29</u> , 19 <u>87</u> , to <u>Sept 16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Sept 16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Dang-Vu | | | | 22c. DATE SIGNED 9/16/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dang-Vu | | | | 22e. ADDRESS Johns-Hopkins Institutions 600 N. Wolfe St. BALTO. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 18, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY SHAAREI ZION | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1987 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be signed by the physician on 28 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial certificate. The funeral director must also complete page 4. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. This certificate is valid only for burial, cremation, or removal.

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SEP 24 1987

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE MARGINS. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ATTACH WITH FORM 10-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25640 | |
|--|--------|--|--|---|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | | | | | | | 2b. HOUR | |
| 1- DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Joseph Finley JR. | | | | | | | | 9 14 19 87 | | M | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (IN YEARS) | | IF UNDER 1 YR. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| MALE | B | 1/9/21 | | 66 RS. | | | | 9 15 19 87 | | 3:23P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED | | NEVER MARRIED | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| BALTO., MD. | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City | | MD | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 2503 Violet Avenue | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MD | | | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2503 VIOLET AVE. | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| JOSEPH FINLEY SR. | | | | BESSIE FINLEY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | N/A | | 218-12-3966 | | ROSE JACKSON 4411 KATHLAND AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple stab wounds | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | | 9 19 87 | | Subject stabbed | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | STATE | |
| | | | | home | | 2503 Violet Ave, | | Baltimore | | MD | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | |
| Mario F. Golle, Jr. M.D. | | | | M.D. Assistant | | | | 9/16/87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | BALTO. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | |
| BURIAL | | | | 9/22/87 | | EASTVIEW CEM. | | BALTO., MD. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| LEROY O. DYETT 4600 LIBERTY HEIGHTS AVE. | | | | SEP 18 1987 | | | | J. B. Borden-Randall | | | |

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2000 COLLECTION LIBRARY

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066970 SEP 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25641

| | | | | | | | |
|--|--|---|---|---|---------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT PAUL FINNAN | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 23, 1987 | | 2b. HOUR 5:00A M | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR OCT. 28 1923 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 63 YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY GUARD | | 12b. KIND OF BUSINESS OR INDUSTRY DETECTIVE AGENCY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY - | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EUGENE JOSEPH FINNAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSALIE MARIE LE FAIVRE | | 13e. STREET ADDRESS / ZIP CODE 620 N. CLINTON ST. 21205 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS ROSALIE WILSON (NIECE) 7813 PERRY RD. 21236 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic cancer</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>1 mth</u> <u>2 yrs</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> 19 <u>87</u> , to <u>9/23</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>John B. Williams M.D. PH.D.</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Williams | | 22e. ADDRESS 600N Wolfe St Baltimore MD 21209 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 9/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | |
| 24. FUNERAL HOME SCHMONEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 25 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

MEDICAL CERTIFICATION

12

1

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by an attending physician, it should be detached for use as the burial-transit permit. Then please remove correct portion of Page 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other medical examiner must be notified of any.

BP

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066278 SEP 18 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should also complete page 4, which should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or a traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 1S, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 25642

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES FISH SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 14, 1987 | | 2b. HOUR 3:55 P |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 7 26 32 | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | 12b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 13a. STATE MD | | 13b. COUNTY | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2036 E. HOFFMAN STREET 21213 |
| 14. FATHER'S NAME FIRST MIDDLE LAST HORRACE SCOTT | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE FISHER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 214-30-3781 | 17. INFORMANT ADDRESS VIVIAN FISHER 2036 E. HOFFMAN STREET | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Staphylococcus endocarditis</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes hours days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>renal failure</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> 19 <u>87</u> , to <u>9-14</u> 19 <u>87</u> , that (I) (we) (we) saw the deceased alive on <u>9-14</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Frederick H. Hesser</u> MO | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9-15-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frederick H. Hesser</u> MO | | 22e. ADDRESS <u>600 N Wake St Balto Md 21205</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/21/87 | 23c. NAME OF CEMETERY OR CREMATORY MOUNT AUBURN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. | | | ADDRESS 1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 |
| | | | 25b. REGISTRAR'S SIGNATURE <u>Deborah R. Rader</u> | | |

068579 239 18 37

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

1- FOR
STATE
REGISTRAR

2- DECEASED NAME
(OR PRINT)

FIRST

MIDDLE

LAST

Leo

Fisher

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 9 1 19 87 7b. HOUR M 4:09

3. SEX

M

4. RACE

W

5. DATE OF BIRTH

12 18 96

6. AGE (IN YEARS)

90 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS

2c. DATE PRONOUNCED DEAD

9 1 19 87

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

825 Freeman Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

BAKER

12b. KIND OF BUSINESS OR INDUSTRY

BAKERY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

825 Freeman St.

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO.

216-01-3739

17. INFORMANT

ADDRESS

Medical Examiner

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐

Inspection ☒

Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☒

Accident ☐

Suicide ☐

Homicide ☐

Undetermined manner ☐

ACTUAL
SIGNATURE

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 9/2/87

EXAMINER'S NAME
(TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

ADDRESS 111 Penn St.

Balto, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Removal

23b. DATE

9-8-87

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR
NAME

ADDRESS

State Anatomy Board

Balto., Md.

25a. DATE REC'D. BY REGISTRAR

SEP 14 1987

25b. REGISTRAR'S SIGNATURE

John Davidson

DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSFERRING PAGE. PAGE 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25044

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME (PRINT) FIRST MIDDLE LAST VERNON GILBERT FITZBERGER | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/20/87 | | 2b. HOUR 9:55 AM |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 5 18 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | 7. GENDER YES |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Clerk | 12b. KIND OF BUSINESS OR INDUSTRY Grocery | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 600 Light Street Apt. #837 21230 |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Henry Fitzberger | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Mae Mills | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 218-09-2267 | 17. INFORMANT ADDRESS Preston L. Fitzberger 66 Gentry Ct. 21403 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hematoma - contusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>multiple fractures</u> 9/15/87 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from <u>9/19</u> , 19 <u>87</u> , to <u>9/20</u> , 19 <u>87</u> , that (we) lost saw the deceased alive on <u>9/20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>J.P. Gladeu, MD</u> | | | | 22c. DATE SIGNED 9/21/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gladeu | | | | 22e. ADDRESS Deaton Medical Center | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/24/87 | 23c. NAME OF CEMETERY OR CREMATORY Western Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | ADDRESS 21229 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1987 | 25b. REGISTRAR'S SIGNATURE Julia Dindon-Rodden |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

JULIA 25645

REG. NO. 458099 FW3

| | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JULIA | | | 2a. DATE OF DEATH MONTH DAY YEAR 8 21 87 | | | 2b. HOUR MIN. 2:00 PM | | | |
| 3. SEX F. | | 4. RACE W. | | 5. DATE OF BIRTH MONTH DAY YEAR 4 12 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. - - - - | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOST. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSING | | 12b. KIND OF BUSINESS OR INDUSTRY INDUSTRIAL | |
| 13a. STATE MD | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE MULBERRY ST - 21240 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM FRANKLIN CHANEY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL ELEANORA SHELEY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | |
| 16b. SOCIAL SECURITY NO. 214-09-3549 | | 17. INFORMANT ADDRESS HELEN J. CHANEY 305 N. MULBERRY ST. HAG. MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Congestive Heart failure | | | | | | | | | |
| 19a. DATE OF OPERATION 9/3 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CONGESTIVE HEART FAILURE | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 PM 19 87 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1303 E COLBURY ROAD BALTO, MD 21239 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 87 , to 9/3 , 19 87 that (I) (we) last saw the deceased alive on 9/3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE B. Atiyeh | | | | DEGREE MD | | | | 22c. DATE SIGNED 9/3/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASSAM ATIYEH | | | | 22e. ADDRESS 1303 E COLBURY ROAD BALTO, MD 21239 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-5-87 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH. MD. | | | |
| 24. FUNERAL DIRECTOR NAME GERALD N. MINNICH | | | | 305 N. POTOMAC STREET HAGERSTOWN, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR SEP 8 - 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rudert</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by a physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

(1)

065355 SEP 14/87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25040
1
1 DECEASED NAME FIRST MIDDLE LAST
(TYPE OR PRINT) Cecelia Agnes Flamm2a. DATE OF DEATH MONTH DAY YEAR
9-8-87
2b. HOUR
10:24 AM3. SEX
Female4. RACE
White5. DATE OF BIRTH
MONTH DAY YEAR
10 23 036. AGE (IN YEARS LAST BIRTHDAY)
83
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN)
(CITY)
Balto., MD7b. CITIZEN OF WHAT COUNTRY?
USA8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD10. CITY OR TOWN OF DEATH
Balto., MD11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Frances Scott Key Hosp.12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker12b. KIND OF BUSINESS OR INDUSTRY
Home13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
13c. CITY OR TOWN13d. INSIDE CITY LIMITS?
YES ☒ NO ☐13e. STREET ADDRESS / ZIP CODE
705 Oldham St., 2122414. FATHER'S NAME FIRST MIDDLE LAST
Simon Fialkowski15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Tomczak16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No16b. SOCIAL SECURITY NO.
212-05-535417. INFORMANT ADDRESS
Margaret Motki (daughter) 1305 Browning Ave. Balto., MD18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c) Cardiogenic shock, etc.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

6 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

Congestive heart failure

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ AT WORK NOT WHILE ☐ AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22. I certify that (I) (this hospital) attended the deceased from Sept. 6, 1987, to Sept. 8, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
Mark T. WorthingtonDEGREE
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒22c. DATE SIGNED
9/8/8722d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark T. Worthington22e. ADDRESS
600 N. Wolfe St., Balto., MD 2120523a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial23b. DATE
9-11-8723c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery23d. LOCATION
CITY OR TOWN COUNTY STATE
Eastwood, Balto., Co., Md.24. FUNERAL DIRECTOR
NAME
Charles S. Zeiler & Son Inc. 6224 Eastern Ave.25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
SEP 10 1987 Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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2008-06-20

-11-

064947 SEP-9187

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD B. FOARD | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 7 87 | | 2b. HOUR 850A M |
| 3 SEX MALE | 4 RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 6 25 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Offset Stripper | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Printing Office |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Halethorpe | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edwin Foard | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Brown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 220-24-0465 | | 17. INFORMANT ADDRESS Elaine R. Foard 1814 Winans Ave. 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminated CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LARGE CELL UNDIFFERENTIATED CARCINOMA, lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that the (this hospital) attended the deceased from <u>Sept. 6</u> 19 <u>87</u> to <u>Sept 7</u> 19 <u>87</u> , that the (we) last saw the deceased alive on <u>Sept 7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Leif J. Morton</u> | | DEGREE | | 22c. DATE SIGNED 9/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORTON | | 22e. ADDRESS St. Agnes Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/10/87 | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | ADDRESS 21229 4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR SEP 08 1987 | 25b. REGISTRAR'S SIGNATURE <u>Frederick R. Riddell</u> |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 5 0 4 8

REG. NO.

FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

HERBERT

F.

FORD

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

9/4/87

10:35 PM

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

9 Sep 15, 1926

6. AGE (IN YEARS LAST BIRTHDAY)

60 yrs

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore city

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

North Charles General Hosp

12a. USUAL OCCUPATION

Security Guard

12b. KIND OF BUSINESS OR INDUSTRY

-

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Fla.

13b. COUNTY

13c. CITY OR TOWN

North Miami

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

14. STREET ADDRESS / ZIP CODE

10845 Biscayne Blvd (33161)

15. FATHER'S NAME

FIRST

Herbert C.

MIDDLE

Ford

LAST

15. MOTHER'S MAIDEN NAME

FIRST

Catherine

MIDDLE

Sherfey

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

-

16b. SOCIAL SECURITY NO.

220-12-9405

17. INFORMANT

ADDRESS

Charles Ford - 3505 Roland Avenue 21211

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

METASTATIC BRAIN CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF

e STATUS EPILEPTICUS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

PLEURAL EFFUSION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

above, (I) (we) did (did not) view the body after death.

9/4 19 87

9/4 19 87

and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

A.C. CHOUVALIT, M.D.

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

9/4/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

A.C. CHOUVALIT

22e. ADDRESS

NORTH CHARLES GENERAL HOSP.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

9/9/87

23c. NAME OF CEMETERY OR CREMATORY

Lorraine Park Cem

23d. LOCATION

Baltimore, Maryland

STATE

24. FUNERAL DIRECTOR

NAME

A. Alan Seitz Funeral Home 3818 Roland Ave.

ADDRESS

25a. DATE REC'D BY REGISTRAR

SEP 08 1987

25b. REGISTRAR'S SIGNATURE

John Davidson

000072 209-061

RECEIVED OCT 100 8002

RECEIVED



SEP 08 1961

066503 SEP 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|--|--|--------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) BABY GIRL FORRESTER | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 16, 1987 | | 2b. HOUR 9:40P | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR SEPT. 16 87 | | |
| 6. AGE (IN YEARS (LAST BIRTHDAY)) YRS MONTHS DAYS 2 10 | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | 10. CITY OR TOWN OF DEATH BALTIMORE | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY MARYLAND VHA | | 13b. CITY OR TOWN ANNAPOLIS | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALBERT PARKER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DIANE FORRESTER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>severe prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hr 10 min</u> <u>2 hr 10 min</u> | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <u>9-16</u> , 19 <u>87</u> , to <u>9-16</u> , 19 <u>87</u> , that (I) (we) saw the deceased alive on <u>9-16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>Elizabeth C Engle MD</u> | | |
| 22c. DATE SIGNED <u>9-16-87</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Elizabeth C Engle</u> | | 22e. ADDRESS <u>JHH 600 N WOLFE ST BALTO MD 21205</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 09/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY THE JOHNS HOPKINS HOSPITAL | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND | | 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D BY REGISTRAR SEP 22 1987 | | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be completed and returned to the hospital or attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", any injury, or other traumatic event, the medicare examiner must be notified at once.

BP

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1 SEP 72 PMS

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65743 SEP 16 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25050
2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
SEPTEMBER 2, 1987 M1. DECEASED NAME FIRST MIDDLE LAST
GEORGE J. FORSYTHE SR.3. SEX 4. RACE 5. DATE OF BIRTH 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YEAR 8. IF UNDER 24 HRS.
MALE WHITE AUG. 06, 1917 70 YRS MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. MD. U.S.A. BALTIMORE CITY MD.10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE 3123 CLEARVIEW AVE FEDERAL RESERVE BANK13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS / ZIP CODE
MARYLAND BALTIMORE YES ☒ NO ☐ 3123 CLEARVIEW AVE 2123414. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
STEPHEN - FORSYTHE MARY UNKNOWN16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS
YES W.W. 2K6-05-0488 - FAMILY RECORDS -18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Carcinoma Prostate
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 weeks 2 years 19 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☒ YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

22a. I certify that (I) (this hospital) attended the deceased from 1968, 19 to 19, that (I) (we) last saw the deceased alive on 9/2, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE 22c. DATE SIGNED
George Abeshouse MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ SEPT. 3, 198722d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS
DR. GEORGE ABESHOUSE 116 SHADE AVE.23a. BURIAL, CREMATION, REMOVAL (CHECK) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL 09-05-1987 PARKWOOD CEM. PARKVILLE, BALTO. CO. MD.24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
EVANS CHAPEL OF MEMORIES ROAD 8800 HARFORD SEP 15 1987 Julia Davidson-Rodgers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

BP

02743 SEP 18 85

067595 OCT-30

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH255851
REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Howard Fosque | | | 2a. DATE OF DEATH MONTH DAY YEAR September 27 1987 | | | 2b. HOUR 8:06 A | | | |
| 3 SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 5 20 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 501 Dolphin Street 21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PERRY Fosque | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA MOORE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-9423 | | 17. INFORMANT ADDRESS Chart | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia; Dehydration. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from September 25, 1987 to September 27, 1987 , that X (we) lost saw the deceased alive on September 27, 1987 , and that XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE A. Pflugrath | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 9/27/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Pflugrath | | | | 22e. ADDRESS C/O Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | 23b. DATE 9/30/87 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON Forest Mt. | | 23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS Mills MD. | | | |
| 24. FUNERAL DIRECTOR NAME E. L. Phillips | | | | ADDRESS 1721 N. MONROE ST. | | 25a. DATE REC'D. BY REGISTRAR OCT-2 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and the results of the various projects. It is a very general and brief summary and does not go into any details.

2. The second part of the report deals with the work of the various departments. It is a more detailed summary of the work done by each department and the results of the various projects. It is a more detailed summary than the first part and goes into more details.

3. The third part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the second part and goes into more details.

4. The fourth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the third part and goes into more details.

5. The fifth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the fourth part and goes into more details.

6. The sixth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the fifth part and goes into more details.

7. The seventh part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the sixth part and goes into more details.

8. The eighth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the seventh part and goes into more details.

9. The ninth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the eighth part and goes into more details.

10. The tenth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the ninth part and goes into more details.

11. The eleventh part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the tenth part and goes into more details.

12. The twelfth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the eleventh part and goes into more details.

13. The thirteenth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the twelfth part and goes into more details.

14. The fourteenth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the thirteenth part and goes into more details.

15. The fifteenth part of the report deals with the work of the various projects. It is a more detailed summary of the work done by each project and the results of the various projects. It is a more detailed summary than the fourteenth part and goes into more details.

066279 SEP 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25652

REG. NO.

FOR
1- STATE
REGISTRAR

2- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Antonio

Foster

(Washington)

3a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 9 15 19 87 3b. HOUR M

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE PRONOUNCED DEAD

M

B

2

5

7

74

13

YRS.

MONTHS

DAYS

HOURS

MIN.

9

15

19

87

7:10P

M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

5100 Lodestone Way

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

N/A

12b. KIND OF BUSINESS OR INDUSTRY

N/A

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

5100 LODESTONE WAY 21206

4. FATHER'S NAME

BILLY

MIDDLE

RAY

LAST

VINE

15. MOTHER'S MAIDEN NAME

BARBARA

MIDDLE

A.

LAST

FOSTER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

220-96-7475

17. INFORMANT

ADDRESS

BARBARA WASHINGTON 5100 LODESTONE WAY

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Perforating gunshot wound of chest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

6:49 AM 9 15 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Subject shot

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

street

21f. LOCATION

5100 Blk. Conant Way, Balto.

COUNTY

STATE

Md.

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

Deputy Chief

M.D.

MEDICAL EXAMINER

DATE SIGNED 9/16/87

EXAMINER'S NAME (TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS

111 Penn St.

Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

9/21/87

23c. NAME OF CEMETERY OR CREMATORY

BALTIMORE CEMETERY

23d. LOCATION

BALTIMORE

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

NAME

WM. C. MARCH F/H, INC.

ADDRESS

1101 E. NORTH AVENUE

25a. DATE REC'D. BY REGISTRAR

SEP 18 1987

25b. REGISTRAR'S SIGNATURE

Ann M. Dixon-Randall

DMHM - 17
(VR A15 ME (5))

BP

07/84
25M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. WITH FORM PM-3, RETAIN PAGE 3 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

000550 209 10 01

100 11 132

065981

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. The physician who examines the body must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove card "Important Notices" and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. The funeral director must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other item marked on the form, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|-----------------------------|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 25653 | | | |
| FOR 1. STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) infant Fraley | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 12 87 | | 2b. HOUR 9:40 PM | |
| 3. SEX Female | | 4. RACE White Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 8 25 87 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS — | | IF UNDER 1 YEAR MONTHS DAYS — 28 | | IF UNDER 24 HRS HOURS MIN — — | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN City | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS ZIP CODE 3249 E. Baltimore St. 21224 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Burn | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sandra Fraley | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Miss Sandra Fraley | | ADDRESS 3249 E. Baltimore Street 21224 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) severe lung disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a severe prematurity, Grade 4 I/V hemorrhage | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. ANESTHESIA YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 12 8 AM 19 87 to Sept 12 19 87, that (I) (we) last saw the deceased alive on Sept 12 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE TRICIA Gomella MD | | | | | | | | | | DEGREE MD | | 22c. DATE SIGNED 9/12/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) TRICIA Gomella | | | | | | | | | | 22e. ADDRESS Key Med Ctr, East Ave. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-16-87 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Joseph N. Zannino Jr. 21224 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

002081 SEP 15 05



66579 SEP 23

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25654

| | | | | | | | |
|--|--|---|--|---|---------------------|---|--|
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERICK ALVIN FRAMPTON, SR. | | | 7a. DATE OF DEATH MONTH DAY YEAR SEPT. 19, 1987 | | 7b. HOUR 7:00 PM | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 15, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 54 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLANT SUPERINTENDENT | | 12b. KIND OF BUSINESS OR INDUSTRY BUFFALO TANK | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN GLEN BURNIE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALVIN FRAMPTON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NARCISSUS WILKINSON | | 13e. STREET ADDRESS / ZIP CODE 1701 KIRK ROAD 21061 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 213.30.1703 | | 17. INFORMANT (WIFE) ADDRESS MARY R. FRAMPTON SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Death</u> DUE TO, OR AS A CONSEQUENCE OF <u>Irreversible Brain Damage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Cerebral Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Infarct</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u> | | | | | | | |
| 19a. DATE OF OPERATION 9/14/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right Cerebral Aneurysm | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>9/14</u> 19 <u>87</u> to <u>9/19</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>9/19</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Charles Cheng</u> | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/19/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES CHENG M.D. | | 22e. ADDRESS Univ. of Maryland Hosp. Balto MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 23, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY MD. VETERANS CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE A.A. MD. | |
| 24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME | | GLEN BURNIE, MD. | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1987 | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove complete pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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[Faint, mostly illegible handwritten text at the bottom of the page, possibly a signature or notes.]

065103 SEP 10 1987

FOR Item 16b, Film G631 per
STATE F.H. 9-18-87 dw
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH25655
REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|--|--|---|--|---|----------------|--|--|---|--|------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| LAWRENCE E. FRANTZ | | | | | | 9 7 1987 | | | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS) (LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | | White | | 11 / 16 / 54 | | 32 YRS. | | | | | | 9 7 1987 | | 11:08 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | Sinai Hospital | | | | Plasterer | | | | Construction | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| Md | | | | -- | | Baltimore | | | | 3850 Quarry Avenue 21211 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Henry Frantz | | | | | | Betty Lou Meeker | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | | | |
| Yes | | | | 1972-1976 | | 220-66-2368 215 10 2806 A | | | | Lynn Frantz Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforating gunshot wound of head (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| | | | | 10:38M. 9-7-1987 | | | | Self-inflicted. | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | home | | | | 3850 Quarry Ave., Balto. MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| | | | | M.D. Deputy Chief | | | | MEDICAL EXAMINER | | | | 9-8-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 9/11/87 | | Md. Veterans Cemetery | | | | Garrison Forest Balto. Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Burgee-Henss Funeral Home | | | | 3631 Falls Rd. 21211 | | | | SEP 9 1987 | | | | Julia Davidson-Landace | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS) AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07:54
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(VR A15 ME (1))

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|-----------------------------------|--|-----------------|--|--------|--|------|--|----------|--|
| 1. DECEASED NAME (LAST OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| IDA | | — | | — | | FRATINI | | Sept. | | 28 | | 87 | | 11 | | 52 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | MONTHS | | DAYS | | HOURS | |
| FEMALE | | CAUCASIAN | | MONTH DAY YEAR 9 17 10 | | 7.7 YRS | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| ITALY | | U.S.A. | | | | BALTIMORE CITY | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| BALTIMORE | | SOUTH BALTIMORE GENERAL HOSP. | | Seamstress | | Clothing | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | | | | | |
| MD | | — | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3809 5 th STREET 21225 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST NED — FRATINI | | FIRST MIDDLE LAST ANNA — SABBATONI | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| Unknown | | 168-09-7263 | | Josephine Fratini | | Same as 13e | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AMYLOID HEART DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CHRONIC RENAL FAILURE</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 16</u> , 19 <u>87</u> , to <u>SEPT 28</u> , 19 <u>87</u> that (I) (we) (they) saw the deceased alive on <u>Sept. 28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Nick E. Musso, MD</u> | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/28/87 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nick E. Musso, MD | | 22e. ADDRESS 3001 S. HANOVER ST, Baltimore, MD | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | 23d. LOCATION Baltimore | | A.A. | | Md | | | | | | | |
| 24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy Balto Md | | 25a. DATE REC'D. BY REGISTRAR OCT - 1 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Dindor-Randall | | | | | | | | | | | | | |

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66547 SEP 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25057

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LYDIA E. FREDERICK | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 21 87 | | | 2b. HOUR 12 P M | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 209 Witherspoon Rd. 21212 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST J. Alan Fledderman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Ball | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 215 68 1708 | | 17. INFORMANT ADDRESS Mr. George J. Bleul 209 Witherspoon Rd. -12 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, Congestive Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 87 , to 9/21 , 19 87 , that (I) (we) lost saw the deceased alive on 9/21 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE David J. Kahan, M.D. | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/21/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID J. KAHAN M.D. | | | | 22e. ADDRESS UNION MEMORIAL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/23/87 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1987 | | 25b. REGISTRAR'S SIGNATURE John Dearden | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 3 and file it with 47 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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20 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 104

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...and I am not alone.

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065708 SEP 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2555
25658
REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Evelyn Freedman | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-8-87 | | 2b. HOUR 955 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 15 XXXX | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 68 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | 12a. USUAL OCCUPATION MERCHANT-FURNITURE RETAIL | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2907 Fallstaff Rd APT. 26 (21209) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ISRAEL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | |
| 16b. SOCIAL SECURITY NUMBER XXX-XX-XXXX | | 17. INFORMANT ADDRESS APT. 26 SIDNEY FREEDMAN 2907 FALLSTAFF RD. 21209 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <u>angine pectoris</u> DUE TO, OR AS A CONSEQUENCE OF (c). <u>coronary artery disease</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/8 19 87 to 9/8 19 87, that (I) (we) last saw the deceased alive on 9/8 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard A. Berg, MD | | | | DEGREE MD | | 22c. DATE SIGNED 9/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Berg, MD | | | | 22e. ADDRESS Suite 365, Commerce Centre East, 1777 Reisterstown Rd, Pikesville, Md 21208 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY BETH JACOB CEM | | 23d. LOCATION CITY OR TOWN COUNTY STATE FINKSBURG CARROLL MD | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 15 1987 | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

002508 SEP 1964

SEP 12 1964

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL FREEDMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 30 87 | | 2b. HOUR 10²⁰ AM |
| 3. SEX MALE | 4. RACE W HITE | 5. DATE OF BIRTH MONTH DAY YEAR 01/15/05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a. USUAL OCCUPATION (IF DECEASED WAS NOT OF WORKING LIFE) MERCHANT | | 12b. KIND OF BUSINESS OR INDUSTRY RETAIL |
| 13a. STATE MD | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4130 FALLSTAFF RD #21215 |
| 14. FATHER'S NAME FIRST MIDDLE LAST ZEISA FARBMAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BUNIE BECHKES | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 213-34-3971A | | 17. INFORMANT DR. IRVING FREEDMAN 4130 FALLSTAFF RD. BALTO., MD 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gangrenous Left Lower Extremity DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES Mellitus | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH | | | | | |
| 19a. DATE OF OPERATION 9/22/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrenous Left Lower Extremity | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/18 19 87 to 9/30 19 87 , that (I) (we) last saw the deceased alive on 9/30 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) LORING I PERRY, M.D. | | 22c. ADDRESS SINAI HOSPITAL | | 22d. DATE SIGNED 9/30/87 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE OCT. 2, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY BETH JACOB ANSHE VESHEAR | |
| 23d. LOCATION CITY ROSEDALE BALTO. MD | | 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 25a. DATE REC'D. BY REGISTRAR OCT 6 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Roads</i> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

06770 OCT-7-01

01 03 05 07 09 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51 53 55 57 59 61 63 65 67 69 71 73 75 77 79 81 83 85 87 89 91 93 95 97 99 101 103 105 107 109 111 113 115 117 119 121 123 125 127 129 131 133 135 137 139 141 143 145 147 149 151 153 155 157 159 161 163 165 167 169 171 173 175 177 179 181 183 185 187 189 191 193 195 197 199 201 203 205 207 209 211 213 215 217 219 221 223 225 227 229 231 233 235 237 239 241 243 245 247 249 251 253 255 257 259 261 263 265 267 269 271 273 275 277 279 281 283 285 287 289 291 293 295 297 299 301 303 305 307 309 311 313 315 317 319 321 323 325 327 329 331 333 335 337 339 341 343 345 347 349 351 353 355 357 359 361 363 365 367 369 371 373 375 377 379 381 383 385 387 389 391 393 395 397 399 401 403 405 407 409 411 413 415 417 419 421 423 425 427 429 431 433 435 437 439 441 443 445 447 449 451 453 455 457 459 461 463 465 467 469 471 473 475 477 479 481 483 485 487 489 491 493 495 497 499 501 503 505 507 509 511 513 515 517 519 521 523 525 527 529 531 533 535 537 539 541 543 545 547 549 551 553 555 557 559 561 563 565 567 569 571 573 575 577 579 581 583 585 587 589 591 593 595 597 599 601 603 605 607 609 611 613 615 617 619 621 623 625 627 629 631 633 635 637 639 641 643 645 647 649 651 653 655 657 659 661 663 665 667 669 671 673 675 677 679 681 683 685 687 689 691 693 695 697 699 701 703 705 707 709 711 713 715 717 719 721 723 725 727 729 731 733 735 737 739 741 743 745 747 749 751 753 755 757 759 761 763 765 767 769 771 773 775 777 779 781 783 785 787 789 791 793 795 797 799 801 803 805 807 809 811 813 815 817 819 821 823 825 827 829 831 833 835 837 839 841 843 845 847 849 851 853 855 857 859 861 863 865 867 869 871 873 875 877 879 881 883 885 887 889 891 893 895 897 899 901 903 905 907 909 911 913 915 917 919 921 923 925 927 929 931 933 935 937 939 941 943 945 947 949 951 953 955 957 959 961 963 965 967 969 971 973 975 977 979 981 983 985 987 989 991 993 995 997 999 1001 1003 1005 1007 1009 1011 1013 1015 1017 1019 1021 1023 1025 1027 1029 1031 1033 1035 1037 1039 1041 1043 1045 1047 1049 1051 1053 1055 1057 1059 1061 1063 1065 1067 1069 1071 1073 1075 1077 1079 1081 1083 1085 1087 1089 1091 1093 1095 1097 1099 1101 1103 1105 1107 1109 1111 1113 1115 1117 1119 1121 1123 1125 1127 1129 1131 1133 1135 1137 1139 1141 1143 1145 1147 1149 1151 1153 1155 1157 1159 1161 1163 1165 1167 1169 1171 1173 1175 1177 1179 1181 1183 1185 1187 1189 1191 1193 1195 1197 1199 1201 1203 1205 1207 1209 1211 1213 1215 1217 1219 1221 1223 1225 1227 1229 1231 1233 1235 1237 1239 1241 1243 1245 1247 1249 1251 1253 1255 1257 1259 1261 1263 1265 1267 1269 1271 1273 1275 1277 1279 1281 1283 1285 1287 1289 1291 1293 1295 1297 1299 1301 1303 1305 1307 1309 1311 1313 1315 1317 1319 1321 1323 1325 1327 1329 1331 1333 1335 1337 1339 1341 1343 1345 1347 1349 1351 1353 1355 1357 1359 1361 1363 1365 1367 1369 1371 1373 1375 1377 1379 1381 1383 1385 1387 1389 1391 1393 1395 1397 1399 1401 1403 1405 1407 1409 1411 1413 1415 1417 1419 1421 1423 1425 1427 1429 1431 1433 1435 1437 1439 1441 1443 1445 1447 1449 1451 1453 1455 1457 1459 1461 1463 1465 1467 1469 1471 1473 1475 1477 1479 1481 1483 1485 1487 1489 1491 1493 1495 1497 1499 1501 1503 1505 1507 1509 1511 1513 1515 1517 1519 1521 1523 1525 1527 1529 1531 1533 1535 1537 1539 1541 1543 1545 1547 1549 1551 1553 1555 1557 1559 1561 1563 1565 1567 1569 1571 1573 1575 1577 1579 1581 1583 1585 1587 1589 1591 1593 1595 1597 1599 1601 1603 1605 1607 1609 1611 1613 1615 1617 1619 1621 1623 1625 1627 1629 1631 1633 1635 1637 1639 1641 1643 1645 1647 1649 1651 1653 1655 1657 1659 1661 1663 1665 1667 1669 1671 1673 1675 1677 1679 1681 1683 1685 1687 1689 1691 1693 1695 1697 1699 1701 1703 1705 1707 1709 1711 1713 1715 1717 1719 1721 1723 1725 1727 1729 1731 1733 1735 1737 1739 1741 1743 1745 1747 1749 1751 1753 1755 1757 1759 1761 1763 1765 1767 1769 1771 1773 1775 1777 1779 1781 1783 1785 1787 1789 1791 1793 1795 1797 1799 1801 1803 1805 1807 1809 1811 1813 1815 1817 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2219 2221 2223 2225 2227 2229 2231 2233 2235 2237 2239 2241 2243 2245 2247 2249 2251 2253 2255 2257 2259 2261 2263 2265 2267 2269 2271 2273 2275 2277 2279 2281 2283 2285 2287 2289 2291 2293 2295 2297 2299 2301 2303 2305 2307 2309 2311 2313 2315 2317 2319 2321 2323 2325 2327 2329 2331 2333 2335 2337 2339 2341 2343 2345 2347 2349 2351 2353 2355 2357 2359 2361 2363 2365 2367 2369 2371 2373 2375 2377 2379 2381 2383 2385 2387 2389 2391 2393 2395 2397 2399 2401 2403 2405 2407 2409 2411 2413 2415 2417 2419 2421 2423 2425 2427 2429 2431 2433 2435 2437 2439 2441 2443 2445 2447 2449 2451 2453 2455 2457 2459 2461 2463 2465 2467 2469 2471 2473 2475 2477 2479 2481 2483 2485 2487 2489 2491 2493 2495 2497 2499 2501 2503 2505 2507 2509 2511 2513 2515 2517 2519 2521 2523 2525 2527 2529 2531 2533 2535 2537 2539 2541 2543 2545 2547 2549 2551 2553 2555 2557 2559 2561 2563 2565 2567 2569 2571 2573 2575 2577 2579 2581 2583 2585 2587 2589 2591 2593 2595 2597 2599 2601 2603 2605 2607 2609 2611 2613 2615 2617 2619 2621 2623 2625 2627 2629 2631 2633 2635 2637 2639 2641 2643 2645 2647 2649 2651 2653 2655 2657 2659 2661 2663 2665 2667 2669 2671 2673 2675 2677 2679 2681 2683 2685 2687 2689 2691 2693 2695 2697 2699 2701 2703 2705 2707 2709 2711 2713 2715 2717 2719 2721 2723 2725 2727 2729 2731 2733 2735 2737 2739 2741 2743 2745 2747 2749 2751 2753 2755 2757 2759 2761 2763 2765 2767 2769 2771 2773 2775 2777 2779 2781 2783 2785 2787 2789 2791 2793 2795 2797 2799 2801 2803 2805 2807 2809 2811 2813 2815 2817 2819 2821 2823 2825 2827 2829 2831 2833 2835 2837 2839 2841 2843 2845 2847 2849 2851 2853 2855 2857 2859 2861 2863 2865 2867 2869 2871 2873 2875 2877 2879 2881 2883 2885 2887 2889 2891 2893 2895 2897 2899 2901 2903 2905 2907 2909 2911 2913 2915 2917 2919 2921 2923 2925 2927 2929 2931 2933 2935 2937 2939 2941 2943 2945 2947 2949 2951 2953 2955 2957 2959 2961 2963 2965 2967 2969 2971 2973 2975 2977 2979 2981 2983 2985 2987 2989 2991 2993 2995 2997 2999 3001 3003 3005 3007 3009 3011 3013 3015 3017 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3419 3421 3423 3425 3427 3429 3431 3433 3435 3437 3439 3441 3443 3445 3447 3449 3451 3453 3455 3457 3459 3461 3463 3465 3467 3469 3471 3473 3475 3477 3479 3481 3483 3485 3487 3489 3491 3493 3495 3497 3499 3501 3503 3505 3507 3509 3511 3513 3515 3517 3519 3521 3523 3525 3527 3529 3531 3533 3535 3537 3539 3541 3543 3545 3547 3549 3551 3553 3555 3557 3559 3561 3563 3565 3567 3569 3571 3573 3575 3577 3579 3581 3583 3585 3587 3589 3591 3593 3595 3597 3599 3601 3603 3605 3607 3609 3611 3613 3615 3617 3619 3621 3623 3625 3627 3629 3631 3633 3635 3637 3639 3641 3643 3645 3647 3649 3651 3653 3655 3657 3659 3661 3663 3665 3667 3669 3671 3673 3675 3677 3679 3681 3683 3685 3687 3689 3691 3693 3695 3697 3699 3701 3703 3705 3707 3709 3711 3713 3715 3717 3719 3721 3723 3725 3727 3729 3731 3733 3735 3737 3739 3741 3743 3745 3747 3749 3751 3753 3755 3757 3759 3761 3763 3765 3767 3769 3771 3773 3775 3777 3779 3781 3783 3785 3787 3789 3791 3793 3795 3797 3799 3801 3803 3805 3807 3809 3811 3813 3815 3817 3819 3821 3823 3825 3827 3829 3831 3833 3835 3837 3839 3841 3843 3845 3847 3849 3851 3853 3855 3857 3859 3861 3863 3865 3867 3869 3871 3873 3875 3877 3879 3881 3883 3885 3887 3889 3891 3893 3895 3897 3899 3901 3903 3905 3907 3909 3911 3913 3915 3917 3919 3921 3923 3925 3927 3929 3931 3933 3935 3937 3939 3941 3943 3945 3947 3949 3951 3953 3955 3957 3959 3961 3963 3965 3967 3969 3971 3973 3975 3977 3979 3981 3983 3985 3987 3989 3991 3993 3995 3997 3999 4001 4003 4005 4007 4009 4011 4013 4015 4017 4019 4021 4023 4025 4027 4029 4031 4033 4035 4037 4039 4041 4043 4045 4047 4049 4051 4053 4055 4057 4059 4061 4063 4065 4067 4069 4071 4073 4075 4077 4079 4081 4083 4085 4087 4089 4091 4093 4095 4097 4099 4101 4103 4105 4107 4109 4111 4113 4115 4117 4119 4121 4123 4125 4127 4129 4131 4133 4135 4137 4139 4141 4143 4145 4147 4149 4151 4153 4155 4157 4159 4161 4163 4165 4167 4169 4171 4173 4175 4177 4179 4181 4183 4185 4187 4189 4191 4193 4195 4197 4199 4201 4203 4205 4207 4209 4211 4213 4215 4217 4219 4221 4223 4225 4227 4229 4231 4233 4235 4237 4239 4241 4243 4245 4247 4249 4251 4253 4255 4257 4259 4261 4263 4265 4267 4269 4271 4273 4275 4277 4279 4281 4283 4285 4287 4289 4291 4293 4295 4297 4299 4301 4303 4305 4307 4309 4311 4313 4315 4317 4319 4321 4323 4325 4327 4329 4331 4333 4335 4337 4339 4341 4343 4345 4347 4349 4351 4353 4355 4357 4359 4361 4363 4365 4367 4369 4371 4373 4375 4377 4379 4381 4383 4385 4387 4389 4391 4393 4395 4397 4399 4401 4403 4405 4407 4409 4411 4413 4415 4417 4419 4421 4423 4425 4427 4429 4431 4433 4435 4437 4439 4441 4443 4445 4447 4449 4451 4453 4455 4457 4459 4461 4463 4465 4467 4469 4471 4473 4475 4477 4479 4481 4483 4485 4487 4489 4491 4493 4495 4497 4499 4501 4503 4505 4507 4509 4511 4513 4515 4517 4519 4521 4523 4525 4527 4529 4531 4533 4535 4537 4539 4541 4543 4545 4547 4549 4551 4553 4555 4557 4559 4561 4563 4565 4567 4569 4571 4573 4575 4577 4579 4581 4583 4585 4587 4589 4591 4593 4595 4597 4599 4601 4603 4605 4607 4609 4611 4613 4615 4617 4619 4621 4623 4625 4627 4629 4631 4633 4635 4637 4639 4641 4643 4645 4647 4649 4651 4653 4655 4657 4659 4661 4663 4665 4667 4669 4671 4673 4675 4677 4679 4681 4683 4685 4687 4689 4691 4693 4695 4697 4699 4701 4703 4705 4707 4709 4711 4713 4715 4717 4719 4721 4723 4725 4727 4729 4731 4733 4735 4737 4739 4741 4743 4745 4747 4749 4751 4753 4755 4757 4759 4761 4763 4765 4767 4769 4771 4773 4775 4777 4779 4781 4783 4785 4787 4789 4791 4793 4795 4797 4799 4801 4803 4805 4807 4809 4811 4813 4815 4817 4819 4821 4823 4825 4827 4829 4831 4833 4835 4837 4839 4841 4843 4845 4847 4849 4851 4853 4855 4857 4859 4861 4863 4865 4867 4869 4871 4873 4875 4877 4879 4881 4883 4885 4887 4889 4891 4893 4895 4897 4899 4901 4903 4905 4907 4909 4911 4913 4915 4917 4919 4921 4923 4925 4927 4929 4931 4933 4935 4937 4939 4941 4943 4945 4947 4949 4951 4953 4955 4957 4959 4961 4963 4965 4967 4969 4971 4973 4975 4977 4979 4981 4983 4985 4987 4989 4991 4993 4995 4997 4999 5001 5003 5005 5007 5009 5011 5013 5015 5017 5019 5021 5023 5025 5027 5029 5031 5033 5035 5037 5039 5041 5043 5045 5047 5049 5051 5053 5055 5057 5059 5061 5063 5065 5067 5069 5071 5073 5075 5077 5079 5081 5083 5085 5087 5089 5091 5093 5095 5097 5099 5101 5103 5105 5107 5109 5111 5113 5115 5117 5119 5121 5123 5125 5127 5129 5131 5133 5135 5137 5139 5141 5143 5145 5

065867 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CATHERINE J. FULLENKAMP | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 14 87 | | | 2b. HOUR 6:45 AM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Martin Trageser | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Stedman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 213-01-7421 | | 17. INFORMANT ADDRESS Mr. John E. Fullenkamp, Jr. Same as #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia with Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a | | | | | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/9/87</u> 19 <u>87</u> to <u>9/14</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>9/14</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (e) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Melkon Hajinazarian</u> | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MELKON HAJINAZARIAN | | | | 22e. ADDRESS Good Samaritan Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph's-Fullerton | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. | | | | ADDRESS Baltimore, Md. 21214 | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Dever-Randall | |

MEDICAL CERTIFICATION

29

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completedly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

062867 2891201

066258 SEP 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anthony L. Fuller | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 14 87 | | | 2b. HOUR 152A.M | |
| 3. SEX M | | 4. RACE B 2 | | 5. DATE OF BIRTH MONTH DAY YEAR 1 1 85 | | 6. AGE (IN YEARS LAST BIRTHDAY) 2 1/2 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | |
| 12b. KIND OF BUSINESS OR INDUSTRY N/A | | 13a. STATE Maryland | | 13b. COUNTY N/A | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Fuller | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Audrey Hall | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | |
| 17. INFORMANT Medical Record | | 18. SOCIAL SECURITY NO. N/A | | 19. STREET ADDRESS / ZIP CODE 558 W. Preston St 21202 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 912 DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis or pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 hrs 9 hrs 1 wk | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Spastic Quadriplegia since age 1 year of age | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 30 PM 9/13, 19 87 , to 9/14 , 19 87 , that (I) (we) lost saw the deceased alive on 9/14 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Vera E. Bennett | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vera E. Bennett | | | | 22e. ADDRESS University of Maryland Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ANNE ARUNDEL CO. MD | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandey | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The Registrar requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. The funeral director should remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. The funeral director should also remove carbon copies. The funeral director should also remove carbon copies. The funeral director should also remove carbon copies.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: This low registration certificate must be secured within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been submitted to the State Registrar, it should be detached for use as the burial-transit permit. The funeral director should completely fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should completely fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should completely fill in by the funeral director, page 3 should be detached for use as the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25662

FOR
STATE
REGISTRATION

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|----------------------------------|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR | | | | | |
| BENNIE L. FULLER | | | SEPTEMBER 5, 1987 | | | 12:58 AM | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | | | 7 UNDER 1 YEAR | | | | | |
| Male | Black | 4/18/21 | 66 YRS | | | MONTHS DAYS HOURS MIN. | | | | | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9b CITIZEN OF WHAT COUNTRY? | 10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | 10b BALTIMORE CITY MD | | | | | |
| S.C. | USA | | BALTIMORE CITY | | | | | | | | |
| 11 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| BALTIMORE | THE JOHNS HOPKINS HOSPITAL | | | Retired | | | longshoreman | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Md. | | | Baltimore | | | 3319 Lynne Haven Dr. 21207 | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b SOCIAL SECURITY NO. | | |
| Julius Fuller | | | Annie Lou Fuller | | | No. | | | 239-14-4169 | | |
| 17 INFORMANT ADDRESS | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Lois Fuller 3319 Lynne Haven Dr. 21207 | | | CARDIOPULMONARY ARREST | | | 50 MIN | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | DUE TO, OR AS A CONSEQUENCE OF | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| SEPSIS, ACIDOSIS, RENAL FAILURE | | | METASTATIC COLON CANCER | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HEPATIC FAILURE, NEW ONSET SEIZURES | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 8/10/87 | | | COLON CANCER | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d INJURY OCCURRED | | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from 7/28, 1987, to 9/5, 1987, that (1) (we) last saw the deceased alive on 9/5, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | DEGREE | | | 22c DATE SIGNED | | | | | |
| Pamela Caslowitz | | | | | | 9/5/87 | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e ADDRESS | | | 22f REGISTRAR'S SIGNATURE | | | | | |
| PAMELA CASLOWITZ | | | JOHNS HOPKINS HOSPITAL | | | John Anderson-Ruders | | | | | |
| 600 N WOLFE ST. BALTO, MD 21205 | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 9/11/87 | | | Kings Park | | | Randallstown Md. | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS | | | 25a DATE OF DEATH | | | 25b REGISTRAR'S SIGNATURE | | | | | |
| Chas. A. Rice FSPA 1300 Eutaw Pl. Cecil A. Rice | | | SEP 9 1987 | | | | | | | | |

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062127

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

066737 SEP 24 1987

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| PAUL FULLER | | | | 9-20-87 | | 6:45 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| M | Negro | 10-10-79 | | 7 YRS | | | |
| 7a. BIRTHPLACE (COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| USA | USA | | | BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | MT WASHINGTON PEDI'S HOSPITAL | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | | |
| MARYLAND | | BALTIMORE | | 2301 CALLOW-1 ST FLOOR 21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| ROY FULLER | | PAULA WAIKER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT NAME ADDRESS | | | |
| NO | | | | Paula DeLoatch 2301 CALLOW ST 1 ST FL BALT. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST | | | | | | | |
| 8147 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 RD HEAD INJURY; SPASTIC QUADRIPARESIS 1 year 35 mos | | | | | | | |
| (c) SEIZURES 2 ND BASILAR SKULL FRACTURE | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SEIZURES | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| | | 1205 PM -4/19 1986 | | Pedestrian/struck by Van | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | Roadway | | 5700 Blk Moravia Road MD | | | |
| 22a. I certify that (this hospital) attended the deceased from 5/23/86, 19 to 9/20/87, 19 that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Dr. Adeloys MD | | MD | | 9/20/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| ETHEL A. ADELOYE MD | | MT. WASHINGTON PEDI'S HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 9/24/87 | | KING MEM. PK. CEMETERY | | RANDALLSTOWN MD | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| WM. C. MARCH INC. 1101 E. NORTH AVENUE | | SEP 23 1987 | | Julia Gordon-Randall | | | |

002137 SEP 24 81

SEP 23 81

65671 SEP 15 87

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--------|---|--|---|--------------------------------------|--|--|
| DECEASED NAME (TYPE OR PRINT) | | FIRST HENRY | MIDDLE | LAST FULTON JR. | 2a. DATE OF DEATH MONTH DAY YEAR 9 7 87 | | 2b. HOUR 4¹⁵ AM | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 6 13 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Allied Chem Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3312 Elgin AVE 21216 | |
| 14. FATHER'S NAME FIRST HENRY | | MIDDLE | | LAST FULTON, SR. | | 15. MOTHER'S MAIDEN NAME FIRST Cellie | | MIDDLE Felder | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. 217264579 | | 17. INFORMANT JUANITA FULTON | | ADDRESS 3312 Elgin AVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC STANDSTILL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a END STAGE RENAL DISEASE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET Arbutus Mem. Pk. | | CITY OR TOWN Arbutus, Md. | | COUNTY Arbutus, Md. | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/21/1987 to 9/7/1987 , that (I) (we) last saw the deceased alive on 9/7/1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Fahim Farhat M.D. | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/7/1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FAHIM FARHAT, M.D. | | | | 22e. ADDRESS GOOD SAMARITAN HOSPITAL OF MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | | 23d. LOCATION CITY OR TOWN Arbutus, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March West | | | | ADDRESS 4300 Wabash Ave. | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Deiden-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. FRISSON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

022671 SEP 12 87

065630 SEP 15 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed as required in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25665

| | | | | |
|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HELEN MAE FUNKHOUSER | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 10, 1987 | | 2b. HOUR A 5:30 M |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 15, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. MAKER | 12b. KIND OF BUSINESS OR INDUSTRY HOME |
| 13a. STATE MD. | 13b. COUNTY MONT. | 13c. CITY OR TOWN GAITHERSBURG | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 444 Girard St. 20877 |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT EDWARD NELSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSABELL - CRAWFORD | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 578-12-1284 | | 17. INFORMANT M. James Gartner, Jr. Same as # 13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>rheumatoid arthritis</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR (A.M. MONTH DAY YEAR) 0530 P.M. 9 10 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> 19 <u>87</u> , to <u>9/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <u>T J Campen</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/10/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) T J Campen | | 22e. ADDRESS St Agnes Hospital Balto, MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE Sept. 12, 1987 | 23c. NAME OF CEMETERY OR CREMATORY LAYTONSVILLE | 23d. LOCATION CITY OR TOWN COUNTY STATE LAYTONSVILLE MONT. MD. | |
| 24. FUNERAL DIRECTOR NAME MURIEL H. BARBER | | ADDRESS LAYTONSVILLE, MD. 20879 | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 |
| | | 25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u> | | |

BP

002630 SEP 12 03



067586 OCT-587

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25666

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Zeddie A. (Furrow) | | | 2a. DATE OF DEATH MONTH 9 DAY 29 YEAR 87 | | | 2b. HOUR 2:34 PM | | | | | |
| 3. SEX F | | 4. RACE B 2 | | 5. DATE OF BIRTH MONTH 7 DAY 26 YEAR 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | 6. AGE (IN YEARS LAST BIRTHDAY) # UNDER 1 YEAR MONTHS 0 DAYS 0 | | 6. AGE (IN YEARS LAST BIRTHDAY) # UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 731 Lynhurst St 21229 | | |
| 14. FATHER'S NAME FIRST Bayley MIDDLE Carter LAST Carter | | | 15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Parker LAST Parker | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 212-22-4961 | | 17. INFORMANT ADDRESS Katie M. Furrow 731 Lynhurst St | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septic shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Decubiti ulcers DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31 19 87 to 9/29 19 87 , that (I) (we) last saw the deceased alive on 9/29 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Bich T Duong | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 9-29-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T DUONG | | | 22e. ADDRESS LIBERTY MEDICAL CENTER | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landsdown Md | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 02 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

29

BP

067248

066640 SEP 24 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 27 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (Type or Print) | | | | 2b. DATE OF DEATH | | 2c. HOUR | |
| | | George LAWRENCE Gardner JR. | | | | 9 21 87 | | 13:30 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS | |
| Male | White | MONTH DAY YEAR 03 18 35 | | 52 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Balti, MD | USA | | | Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) | | | 12a. USUAL OCCUPATION (Type of work for most of working life) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | U.M.C.C. | | | Salesman | | | Lawn/Garden | | |
| 13a. USUAL RESIDENCE (If nursing home or other institution, give residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | |
| MO | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4311 Grandview Ave. 21211 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. ADDRESS | | | | | |
| George | | Mary | | Pedone | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| Yes | | 1957-1963 | | Edna M. Gardner 4311 Grandview Ave. 21211 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) <u>metastatic Lung Cancer</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.) | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-20</u> 19 <u>87</u> to <u>9-21</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| <u>Edna M. Gardner</u> | | | | | | | | 9/21 87 | |
| 22d. PHYSICIAN'S NAME (Type or Print) | | | | 22e. ADDRESS | | | | | |
| EUN MI PARK | | | | 22nd S. Greene Street. UMCC. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 9-24-1987 | | Lakeview memorial Park | | Sykesville, Carroll, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Burgee-Henss Funeral Home 3631 Falls Road | | | | SEP 23 1987 | | <u>Julia Sander-Randall</u> | | | |

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064946 SEA-987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25668

REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles | | | 2a. DATE OF DEATH MONTH 9 DAY 6 YEAR 87 | | | 2b. HOUR M | | | |
| 3. SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 5 DAY 17 YEAR 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS | | 7. IF UNDER 1 YEAR MONTHS 8 DAYS 17 HOURS 17 MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD. | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Poplar Manor Nursing Home | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Latimer | | 15. KIND OF BUSINESS OR INDUSTRY Shipyard | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland 16b. COUNTY Baltimore 16c. CITY OR TOWN Baltimore | | | | | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18. STREET ADDRESS 201 N. Broadway Apt. 16M | | |
| 19. FATHER'S NAME FIRST ELIZAB MIDDLE BUCK LAST HAMMON | | | | | 20. MOTHER'S MAIDEN NAME FIRST SARAH MIDDLE JACKSON LAST 21231 | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 22. SOCIAL SECURITY NO. 218-07-4028A | | 23. INFORMANT ada barto 201 N. Broadway | | |

| | | | |
|---|--|---|--|
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAL ARRYTHMIA | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASUHO | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes | | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 25a. DATE OF OPERATION | | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 26a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 28a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 28c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 29. I certify that (I) (this hospital) attended the deceased from 9/4/87 , 19 87 , to 9/6 , 19 87 , that (I) (we) last saw the deceased alive on 9/3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 29a. SIGNATURE M. Davis MD | | | | 29b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 29c. DATE SIGNED 9/7/87 | |
| 29d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIC DAVIS MD | | | | 29e. ADDRESS 9141 BART NORT AVE ELMD 21023 | | | |
| 30a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 30b. DATE 9/11/87 | | 30c. NAME OF CEMETERY OR CREMATORY Ind-National Mem | | 30d. LOCATION CITY OR TOWN COUNTY STATE Lanham, Md. | |
| 31. FUNERAL DIRECTOR NAME Loche Funeral Home ADDRESS 1304 N. Baltimore | | | | 32. DATE REC'D. BY REGISTRAR SEP 08 1987 | | 33. REGISTRAR'S SIGNATURE [Signature] | |

DHMH-16 25M
(VRA 15, 4) 1/79

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the permit to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 19 above any injury, or other traumatic event, the medical examiner must be notified at once.

001318 SEP-81

SEP 8 1981

166596 SEP 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25669

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles W. Ganley | | | 2a. DATE OF DEATH MONTH DAY YEAR September 21, 1987 | | | 2b. HOUR M M | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 12/07/01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD | | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Villa | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) electrician | | 12b. KIND OF BUSINESS OR INDUSTRY self | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Arbutus | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1228 North Avenue 21227 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William A. Ganley | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche A. Sollers | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 17-20-3712 | | 17. INFORMANT Mrs. Shirley Stevens 925 Leeds Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cong. Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) AS CVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Bermania (b) dihydro | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug. 19 87, to 9/21 19 87, that (I) (we) last saw the deceased alive on 9/21 19 87, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Dr. Elmo M. Gausso, M.D. | | | | | | 22c. DATE SIGNED 9/23/87 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Elmo M. Gausso, M.D. | | |
| 22e. ADDRESS 5411 Old Frederick Road 21228-744-3950 | | | | | | 22f. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | 23b. DATE 9/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | | 23d. LOCATION Baltimore City Maryland STATE | | |
| 24. FUNERAL DIRECTOR NAME Ambrose Funeral Home 1328 Sulphur Spring Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1987 | | 25b. REGISTRAR'S SIGNATURE Julia D. Linder | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (page 1) and it should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner will be notified and a medical investigation will be conducted.

BP

002200 205 54 01



SEP 23 1961

66234 SEP 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25070

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | |
|--|--|---------------------------|--|---|------------------------------------|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Gloria Gardner | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9/ 16/ 19 87 | | | 2b. HOUR M 4:12 P | | | | | | | |
| 3. SEX Female | | 4. RACE Negroid | | 5. DATE OF BIRTH MONTH DAY YEAR 1-7-38 | | 6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS. | | 7. DATE MONTH DAY YEAR 9/ 16/ 19 87 | | 7a. HOUR M 4:12 P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN E. FACILITY, GIVE STREET ADDRESS) 1205 E. Federal St. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1705 E. Federal St. | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Gardner | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanette Keene | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 212-34-5589 | | | 17. INFORMANT ADDRESS Tressa Gardner Federal St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above below. Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | | | TITLE (SPECIFY) D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 9/17/87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Indicate) | | | | 23b. DATE 9-22-87 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD. | | | |
| 24. FUNERAL DIRECTOR NAME CALVIN B. Scruggs | | | | | | ADDRESS 1412 E. Preston St. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Dindon-Randall</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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066285 SEP 18 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|--|--|-----|
| 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jane Gardner | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 16 87 | | | 2b. HOUR 0600 M | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YR 7 29 33 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED | |
| 13a. STATE MD | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. STREET ADDRESS 6305 MONIKA PLACE APT 1401 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN WHITE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH LYNCH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 242-54-5195 | | 17. INFORMANT ADDRESS WILLIAM GARDNER 6305 Monika Place | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) BRAIN STEM INFARCTION (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | | | | | | | 18. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebro Vascular Accident January 87. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 12 19 87 , to Sept 16 19 87 , that (I) (we) last saw the deceased alive on Sept 16 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Fernando Fernandez | | | | DEGREE | | 22c. DATE SIGNED 9/16/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FERNANDO FERNANDEZ | | | | 22e. ADDRESS ST Agnes Hospital 900 charon Ave Baltimore MD 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/21/87 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST CEM | | 23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H INC. 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the statement be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE UNIVERSITY OF CHICAGO

LIBRARY

1993

269 18 93

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25672

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|---|--|--------|-------|---|--|------------------|--|--|--------------|---------------------|--|-------------------------------------|---|--|--|----------|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a DATE KNOWN OF DEATH | | | | 2b HOUR | | | |
| Gregory | | | C. | | | Garner | | | 9/ 30/ 19 87 | | | | M | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c DATE PRONOUNCED DEAD | | | | 7d HOUR | | | |
| MALE | | BLACK | | 12 3 55 | | 31 YRS. | | MONTHS | | DAYS | | 9/ 30/ 19 87 | | | | 2:45 P M | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b CITIZEN OF WHAT COUNTRY? | | | | 8 MARRIED | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MARYLAND | | | | U.S. | | | | WIDOWED | | | | Baltimore City, | | | | MD | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a USUAL OCCUPATION (TYPE OF WORK) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | | | 5306 Ethelbert Ave. | | | | UNEMPLOYED | | | | | | | | | | | |
| 13a STATE | | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | | | | | | | |
| Maryland | | | | | | BALTIMORE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 5306 ETHELBERG AVE. | | | | | | | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| LEXIE | | | | GARNER | | | | MOLLIE | | | | STATION | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b SOCIAL SECURITY NO. | | | | 17 INFORMANT | | | | ADDRESS | | | | | | | |
| NO | | | | 220-64-4591 | | | | CHART | | | | | | | | | | | |

| | | | |
|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) | | Narcotic Intoxication | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

| | | | | | |
|--|--|--|--|---|--|
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR XX MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2 | |
| | | 2:35 P.M. 9/ 30/ 1987 | | subject used drugs | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY | | 21f LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> | | STREET, FACTORY, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | |
| AT WORK AT WORK | | bathroom | | 5306 Ethelbert Ave., Balto. City, Md. | |

| | | | |
|---|--|--|--|
| 22a I certify that I took charge of the remains described above, held an | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| death resulted from | | Undetermined manner <input checked="" type="checkbox"/> | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> | | | |

| | | | |
|-----------------------|--|-------------|--|
| ACTUAL SIGNATURE | | DATE SIGNED | |
| Dennis F. Smyth, M.D. | | 10/1/87 | |

| | | | | | | | |
|--------------------------------|--|----------|--|-----------------------------------|--|--------------|--|
| 23a BURIAL, CREMATION, REMOVAL | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | |
| Burial | | 10/5/87 | | KING MEM. PK. | | BALTIMORE MD | |

| | | | | | |
|--------------------------------------|--|------------------------------|--|---------------------------|--|
| 24 FUNERAL DIRECTOR | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | OCT - 2 1987 | | Julia Davidson-Randall | |
| E.L. Phillips 1721 N. MONTGOMERY ST. | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (GIVE PAGE NO. 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

DHMH - 17
(VR A15 ME (1))

067207 OCT-20

20% COTTON FIBER

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST RUTH | | MIDDLE E. | | LAST GARRISON | | 2a. DATE OF DEATH MONTH DAY YEAR 9-16-87 | | 7a. HOUR 3 30 A.M. | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 03 03 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | 7b. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7c. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESPERSON | | 12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2814 Erdman Avenue, 21213 2814 Erdman Ave. 21213 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MAURICE HARTZELL | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE RUSSELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY # 46 0334 79 | | 16c. BIRTH # 21213 | | 17. INFORMANT PATRICIA SPARKS (DGHTER) | | ADDRESS 3006 EVERGREEN AVE. 21214 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-9</u> , 19 <u>87</u> , to <u>9-16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9-16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Ginny Merryman MD | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9-16-87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ginny Merryman | | | | | | 22e. ADDRESS Mercy Hosp. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/19/87 | | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE James Davidson-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it is completely filled in by the funeral director. page 3 should be detached for use as the burial transit permit. Then please remove carbon-copy Paper 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medicolegal examination must be held at once.

BP.

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Film G632 item 1 10/2/87 rja

FOR STATE Item 14, Film G632 10-1-87

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CLIFTON | | FIRST GEE | | LAST SR | | 2a. DATE OF DEATH MONTH DAY YEAR 09 26 87 | | 2b. HOUR 10.05 AM | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 10 28 42 | | 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | | | |
| 10. CITY OR TOWN OF DEATH city | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2212 PRESSTMAN STREET 21216 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CLIFTON Clifford GEE SR. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCILLE SMITH | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS LUCILLE GEE 2212 PRESSTMAN STREET | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF SEVERE DILATED CARDIOMYOPATHY (b) CEREBRAL VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 09/21 87 9/26 87 | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/26 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Kuang-yen Huang | | | | DEGREE MD | | | | 22c. DATE SIGNED 9/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG | | | | 22e. ADDRESS BON SECOURS Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/1/87 | | 23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL, MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1987 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the coroner or medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---|--|-------------------|
| 1. STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| FIRST MIDDLE LAST | | 09/26/87 | | 10:45 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Male | white | MONTH DAY YEAR | 64 YRS | Baltimore City MD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Maryland | USA | | Retired | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | Loch Raven Veterans Hospital | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| Maryland | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2000 Odell Ave. Baltimore MD 21237 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | 16b. SOCIAL SECURITY NO. | | | |
| Francis T. Gera | Carolyn Seyer | 216-18-3704 | | | |
| 17. INFORMANT | | ADDRESS | | | |
| Brenda McCarthy | | 4216 Colb Ave. 21206 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) <u>Lung carcinoma with metastases to brain</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/26/87</u> to <u>9/26/87</u> , that (I) (we) last saw the deceased alive on <u>9/26/87</u> , and that in (my) (our) opinion death occurred on the <u>same</u> date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Maria M. Garcia MD | | | | 9/26/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Maria M. Garcia | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | 23e. COUNTY STATE |
| Burial | | 9/30/87 | Md. Veterans Cemetery | Garrison Forest | Maryland |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | SEP 29 1987 | | [Signature] | |
| A. Alan Seitz, Jr. 3818 Roland Ave. 21211 | | | | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

| | | | | | | | | | | | |
|--|---------------------|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Stephen | | FIRST Stephen | | MIDDLE Germers | | LAST hausen | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 11 19 87 | | 2b. HOUR M | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 10/25/58 | | 6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 11 19 87 | | 2d. HOUR 12:05 a M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? — | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern District Police Station | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OR WORKING LIFE) Painter | | 12b. KIND OF BUSINESS OR INDUSTRY — | | | |
| 13a. STATE Md. | | 13b. COUNTY — | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 315 E. Cross St. 21230 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Philip Germershausen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Grohawn | | | | 16. SOCIAL SECURITY NO. 318-78-6993 | | | |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 100 - | | 14b. SOCIAL SECURITY NO. 318-78-6993 | | 17. INFORMANT Gertrude Germershausen | | 17a. ADDRESS 315 E. Cross St. 21230 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 9 10 19 87 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject hanged self | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) jail cell | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Southern District Police Station, Balto City, MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles P. Kokes | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 9/11/87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. | | | | ADDRESS 111 Penn St. | | | | BALTO. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE 9/14/87 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem. | | 23d. LOCATION Do Ritchie & Shady Md. | | 23e. DATE REC'D. BY REGISTRAR SEP 14 1987 | | | |
| 23f. REGISTRAR'S SIGNATURE Charles P. Kokes | | | | 23g. REGISTRAR'S SIGNATURE Julia T. R. R. R. | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25678
REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|---------|-------------------|--|--|------------------------------------|--|---|----------------|---------------------------|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| Terry Warren Gibson | | | | | | 9-6-1987 | | | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | | White | | 5 18 51 | | 36 | | MONTHS DAYS | | HOURS MIN. | | 9-6-1987 | | 11:42 P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | U.S.A. | | | | WIDOWED NEVER MARRIED DIVORCED | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | Francis Scott Key Medical Center | | | | Unemployed | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | | | | | Baltimore | | YES NO | | 416 S. Clinton St. 21224 | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| George W. Gibson | | | | Ann Schuld | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | Unknown | | | | Ann Gibson | | | | 819 S. Ponca Street 21224 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple Gunshot Wounds | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES NO | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED | | | | | | | |
| | | | | 10:23PM 9-6-87 | | | | Subject shot by Police | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY | | | | 21f. LOCATION | | | | | | | |
| | | | | building | | | | 416 S. Clinton Street, Baltimore City, Balto., MD | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| Dennis F. Smyth, M.D. | | | | Assistant | | | | 9-7-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | | | 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| Burial | | | | 9-10-87 | | Oak Lawn Cemetery | | | | Cathwood, Balto., Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Charles S. Zeiler & Son Inc. | | | | 6224 Eastern Ave. | | | | SEP 10 1987 | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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065184 SEP 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87-25079

REG NO

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|--|--|--|---|--|
| 2a DECEASED NAME (TYPE OR PRINT) BERENICE R. GILBERT | | | 2b DATE OF DEATH MONTH DAY YEAR Sept. 5, 1987 | | 2c HOUR M |
| 3 SEX Female | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR May 22, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 | # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Home | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a STATE MD | 13b COUNTY | 13c CITY OR TOWN Balto. | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE 218 E. Lake St., 21212 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Albert Reichle | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Essie Langenbacher | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b SOCIAL SECURITY NO. 167 09 8660 | 17 INFORMANT ADDRESS W. Floyd Gilbert, Same | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Alcoholism, cirrhosis | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 87, to Sept 5, 19 87, that (I) (we) last saw the deceased alive on 9/1, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert J. Vissing, MD | | DEGREE MD | | 22c. DATE SIGNED 7/8/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Vissing, MD | | 22e. ADDRESS 4300 N. Charles St., Balto., MD | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/9/87 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, MD | |
| 24 FUNERAL DIRECTOR NAME H.W. Jenkins, | | ADDRESS 21212 | | 25a. DATE REC'D. BY REGISTRAR SEP 09 1987 | 25b. REGISTRAR'S SIGNATURE |

MEDICAL CERTIFICATION

279

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 2 and 3 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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SEP 08 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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067292 OCT 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| | | | | | |
|---|--------|--|--------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| FIRST MIDDLE LAST | | 9 24 1987 | | 11 AM | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | 78 | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| New Jersey | | USA | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore City | | The Union Memorial Hospital | | Baltimore MD | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Baltimore | | Towson | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 16b. SOCIAL SECURITY NO. | |
| John Gildea | | Annie Moran | | 212-07-8027 A | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH | |
| William J. Gildea, Jr. | | 5904 Cobalt Rd. | | PART 1. DEATH WAS CAUSED BY: | |
| Bethesda, Md. 20816 | | | | IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST.</u> | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | |
| | | | | (b) <u>SEPTICEMIA</u> | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | |
| | | | | (c) <u>PNEUMONIA, MALNUTRITION</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>S/PRT. Colectomy for carcinoma of colon, CL. DIF TOXIN DIARRHEA, MALNUTRITION, STAPHYLOCOCCUS</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| 9/12/87, 8/14/87 | | 1. HICKMAN CATH PLACEMENT 2. RT COLON CA | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/22/87</u> 19 <u>87</u> to <u>9/24</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | |
| DEGREE | | | | | |
| Dwarkanum MD R2 Resident - ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 9/24/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| Dwarkanum | | | | THE UNION MEMORIAL HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/26/87 | | New Cathedral | |
| 23d. LOCATION | | 23e. NAME OF CEMETERY OR CREMATORY | | 23f. LOCATION | |
| Baltimore City, Maryland | | Baltimore City, Maryland | | Baltimore City, Maryland | |
| 24. FUNERAL DIRECTOR | | 25a. DATE RECEIVED BY REGISTER | | 25b. REGISTER SIGNATURE | |
| NAME ADDRESS | | 6500 York Rd. | | SEP 30 1987 | |
| Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | | |

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MAINTAINED
20% COTTON BLEND



Handwritten notes and stamps are visible on the left side of the document, including a date stamp "OCT 19 1981" and various illegible markings.

067195 SEP 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|-----------------------------|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BARBARA E. GILLIS | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 25 87 | | 2b. HOUR 8 50 P M | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 9 20 16 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home Maker | |
| 13a. STATE MARYLAND | | 13b. COUNTY == | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM - KELLER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAUDE - FORREST | | 13e. STREET ADDRESS / ZIP CODE 3800 4th St. 21225 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 219-22-3627 | | 17. INFORMANT Clinton I. Gillis | | ADDRESS Balto Md 21201 524 N Charles St Apt 1113 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Adult Resp. Distress Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/27 , 19 87 , to 9/25 , 19 87 , that (I) (we) last saw the deceased alive on 9/25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dr. J. Musso, MD | | | | DEGREE MD | | 22c. DATE SIGNED 9/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUSSO | | | | 22e. ADDRESS 3001 S. Hanover St., Baltimore, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/29/87 | | 23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery | | 23d. LOCATION CITY/TOWN COUNTY STATE Mt Airy Carroll Md | |
| 24. FUNERAL DIRECTOR George J. Gonca 4001 Ritchie Hwy Balto Md | | | | 25a. DATE REC'D BY REGISTRAR SEP 29 1987 | | 25b. REGISTRAR'S SIGNATURE Julian D. ... | |

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOV 1984

Handwritten notes on lined paper, including the word "STATION" and various illegible entries.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Ann</i> MIDDLE <i>A B.</i> LAST <i>Ginner</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9/22/87</i> | | | 2b. HOUR <i>1:15 Am</i> M | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>2 14 60</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>27</i> YRS | | IF UNDER 1 YEAR IF UNDER 74 HRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <i>RUSSIA</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Balt.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hosp.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION): 13a. STATE <i>MD</i> 13b. COUNTY <i>BALCO</i> 13c. CITY OR TOWN <i>Baltimore</i> | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>A Abraham Abramson</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELLA NETTIE POSNANSKY</i> <i>Anna Ellen Abramson</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. <i>318-34-8033</i> | | 17. INFORMANT <i>MRS. GLORIA BROOKS</i> <i>3503 W. STRATHMORE AVE. BALTO., MD 21215</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac ARREST</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9/22/87</i> <i>9/01/87</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-1-87</i> , 19 <i>87</i> , to <i>9-22/87</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>9/22</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE <i>K. G. Ginner</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>9/22/87</i> | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kerstin Gill</i> | | | | | | 22e. ADDRESS <i>Greenspring + Belvedere Balt md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>SEPT. 27, 1987</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>CHIZUK AMUNO</i> | | 23d. LOCATION CITY STATE COUNTY <i>BALTIMORE MARYLAND</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>SOL LEVINSON & BROS., INC.</i> <i>6010 REISTERSTOWN RD. BALTO., MD</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>5 OCT 1 1987</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. M. ...</i> | |

BP

01-100-501

100-100-501

066329

SEP 22 87

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|---|---|--------|--|--|--|---|------------------|---|------|
| DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | MIN. |
| MAURICE GLASSER | | | | | 9 | 19 | 87 | | 5:00A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | White | MONTH DAY YEAR 5 15 12 | | 75 YRS. | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| NEW YORK | U.S.A. | | | Baltimore City MD | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | 717 Winans Way | | | Service Station | | Gas Station | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Glasser | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | |
| NO | | 216-03-0571 | | Dorothy E. Glasser 717 Winans Way 21229 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> | | | | | | | | | 6 months | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA - BROWNEGENE</u> | | | | | | | | | 1 1/2 years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC-1985</u> , 19 <u>85</u> , to <u>SEPT 19</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>SEPT 18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Norman Keeman MD</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kleiman NORMAN R. | | | | 22e. ADDRESS 3803 Edmondson Avenue | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Cremation | | 9/21/87 | | Security Process Crem. | | Catonsville Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 21 1987 <u>J. Davidson-Rodriguez</u> | | | | | | |

MEDICAL CERTIFICATION

9
9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury for other than a traumatic event, the medical examiner must be notified at once.

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RECEIVED

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RECEIVED

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066200 SEP 8 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) JUANITA GLAVIANO | | | 2a DATE OF DEATH MONTH DAY YEAR 9 16 87 | | | 2b HOUR 12:10 P.M. | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 6 28 21 | | 6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY --- | |
| 13a STATE Maryland | | 13b COUNTY --- | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST James Alison Kennard | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lulu Lester | | 13e STREET ADDRESS / ZIP CODE 432 Furrow Street, 21223 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 278-18-7555 | | 17 INFORMANT Anthony J. Glaviano, 432 Furrow Street | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic OBSTRUCTIVE PULMONARY DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>9/13/87</i> 19, to <i>9/16/87</i> 19, that (I) (we) lost saw the deceased alive on <i>9/13/87</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) the body after death. | | | | | | | |
| 22b SIGNATURE <i>J. Shorofsky M.D.</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <i>9/16/87</i> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. SBOROFSKY | | | | 22e ADDRESS 7929 STEVENSON Road Pikesville | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 9/19/87 | | 23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | | | ADDRESS 21229 4107 WILKENS AVE. | | 25a DATE REC'D BY REGISTRAR SEP 18 1987 | |
| | | | | 25b REGISTRAR'S SIGNATURE <i>William R. Rudee</i> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8725085

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| DECEASED NAME (TYPE OR PRINT) STEFANIA | | FIRST GLAZER | | LAST GLAZER | | 7a DATE OF DEATH MONTH DAY YEAR SEPTEMBER 7, 1987 | | 7b HOUR 4:47A.M. | |
| 3 SEX FEMALE | | 4 RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 15, 1898 | | 6 AGE (IN YEARS LAST BIRTHDAY) 89 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY AT HOME | | | |
| 13a STATE MARYLAND | | 13b COUNTY BALTIMORE | | 13c CITY OR TOWN BALTIMORE | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 7032 SURREY DRIVE 21215 | |
| FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ZISEL | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b SOCIAL SECURITY NO. 215-40-1482A | | 17 INFORMANT ADDRESS ALFRED GLAZER 7032 SURREY DRIVE. 21215 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease - atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>diabetes mellitus</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>July 17</u> , 19 <u>71</u> , to <u>Sept 7</u> , 19 <u>87</u> , that (I) (we) saw the deceased alive on <u>Aug 19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <u>Manuel Levin MD</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED <u>9/7/87</u> | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. MANUEL LEVIN | | 22e ADDRESS 6101 PARK HTS. AVE. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 9/8/87 | | 23c PROGRESSIVE BENEFIT & RELIEF ASSOC. CEMETERY PROGRESSIVE BENEFIT & RELIEF ASSOC. CEMETERY | | 23d BALTO., MD | | 23e COUNTY STATE | |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | 6010 REISTERSTOWN RD. BALTIMORE, MD 21215 | | 25a DATE REC'D. BY REGISTRAR SEP 09 1987 | | 25b REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25080

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|-----------------------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDNA GLOVER | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 17 87 | | | 2b. HOUR 8.06 M | | | | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2-8-04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 72 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 1010 W. Baltimore St. 2127.3 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 219-14-1609 | | 17. INFORMANT ADDRESS Catherine Sparrow 2446 WILGREY CT. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS - STAPH. SEPSIS DUE TO, OR AS A CONSEQUENCE OF RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic Mellitus (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a LLL Pneumonia | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/17 1987 to 9/17 1987, that (I) (we) last saw the deceased on 9/17 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Ambacher Woreth DEGREE MD | | | | | | | | | | 22c. DATE SIGNED 9/17/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMBACHER WORETH | | | | | | | | | | 22e. ADDRESS LIBERTY MEDICAL CENTER | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-22-87 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Brown-Thompson F.H. ADDRESS P.O. Box 4433 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Benson-Randall | |

MEDICAL CERTIFICATION

9/9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARRY GODWIN | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-1-87 | | | 2b. HOUR 10:30 P.M. | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2 18 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sup. (Meter Reader) | |
| 12b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. | | 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Arbutus | |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1710 Arbutus Ave. | | 13f. ZIP CODE 21227 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander godwin | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Malone | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 215-16-2198 | |
| 16c. IF YES, GIVE WAR OR DATES WW II | | 17. INFORMANT Dorothy J. Godwin | | 17. ADDRESS 1710 Arbutus Ave. | | 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic tumor DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 1987, to Sept 1, 1987, that (I) (we) lost saw the deceased alive on Sept 1, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael K. RO | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/2/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL K. RO | | 22e. ADDRESS St. Agnes Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/4/87 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, INC. | | ADDRESS 4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR SEP 04 1987 | | | |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 4 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

084832 SEP-80

SEP 04 1980

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

065983

SEP 17 1987

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|--|--|--|--|---|--|--|---|--|---|--|--|
| 1. DECEASED'S NAME (TYPE OR PRINT) | | | 20. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | | |
| FIRST MIDDLE LAST Wilbert GODWIN | | | September 14, 1987 | | | 9:30A M | | | | | |
| 3. SEX M | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 5 2 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. ROBESON | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY RETIRED | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2203 W LEXINGTON ST 21223 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JERRY GODWIN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MADHA POWELL | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS BERTHA GODWIN 2203 W LEXINGTON ST | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carinoma of the esophageal with</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>diffuse hepatic involvement</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Adenocarcinoma of the prostate</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED DURING <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that x (this hospital) attended the deceased from <u>August 15</u> 19 <u>87</u> to <u>September 14</u> 19 <u>87</u> that x (we) last saw the deceased alive on <u>September 14</u> 19 <u>87</u> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above (x) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Harry M. Harris</i> | | | | | | DEGREE M.D. | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Harris, M.D. | | | | | | 22e. ADDRESS c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9/21/87 | | 23c. NAME OF CEMETERY OR CREMATORY MD NATIONAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS BETH'S FUNERAL HOME 1129 N. CAROLINE ST. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davis</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

082003 SEP 17 61

SEP 18 1961

064959 SEP -987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|---|---|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE R. GOELLER | | | 2a. DATE OF DEATH MONTH DAY YEAR September 7, 1987 | | 2b. HOUR 8 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 16, 1907 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1349 Crofton Rd. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.- Western Union | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Linden Eugene Richardson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Anna Touchton | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-09-9374 | | 17. INFORMANT Mrs. Anna M. Douglass Same as #13c | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 31 , 19 65 , to SEPT 8 , 19 87 , that (I) (we) last saw the deceased alive on SEPT 4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Sam O'Mansky | | DEGREE M.D. | | 22c. DATE SIGNED 9/8/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel O'Mansky, M.D. | | 22e. ADDRESS 8405 Loch Raven Blvd. Apt A | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-10-87 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1987 | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Md. | | 25b. REGISTRAR'S SIGNATURE William Ruck | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please inform the coroner's inquest. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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|---|--|--|---|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) SOPHIE SOPHIA GOLDSTEIN | | | 2a DATE OF DEATH MONTH DAY YEAR 9 14 87 | | | 2b HOUR M 8:30 | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 8 26 1898 | | 6 AGE (IN YEARS LAST BIRTHDAY) 93 89 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a STATE MARYLAND | | | 13b COUNTY | | 13c CITY OR TOWN BALTO. | | |
| 14 FATHER'S NAME UNKNOWN | | | 15 MOTHER'S MAIDEN NAME UNKNOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b SOCIAL SECURITY NO. 216-32-6053 | | 17 INFORMANT MR. ARTHUR DRAGER ADDRESS 5 LIGHT ST. BALTO. MD 21202 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 2 18 19 86 to 9 14 19 87, that (I) (we) last saw the deceased alive on 9 14 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE E. G. [Signature] | | | | DEGREE M.D. | | 22c DATE SIGNED 9-14-87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) SET HEWAR | | | | 22e ADDRESS Levindale. 2434 W. Belverdere Ave. Baltimore, Md. 21215 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE SEPT. 15, 1987 | | 23c NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK | | 23d LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO. MD | |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS, INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a DATE REC'D. BY REGISTRAR SEP 17 1987 | | 25b REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|---------|--|-------------------------|---|---------------------------------|---|---------------------|--|------------------|--|
| DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| PATRICIA | | LOUISE | GOMER | 9 | | 13 | 87 | 9 | 35 | A.M. |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS. | |
| FEMALE | WHITE | | MONTH 12 DAY 22 YEAR 28 | | 58 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9b. CITIZEN OF WHAT COUNTRY? | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | ST. AGNES HOSPITAL | | | | COMETITICIAN | | HECHTS | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2216 WEST PATAPSCO AVE. 21230 | | |
| MARYLAND | | | | BALTIMORE | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| FIRST MIDDLE LAST LOWELL ALDERTON | | FIRST MIDDLE LAST MARY E STEVENS | | NO | | 219-22-0583 | | SANDRA L. MILLER 300 NORTH CHAPELGATE LANE. 21229 APT. E | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-18</u> 19 <u>87</u> , to <u>9-13</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9-13</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | |
| <u>Gordon S. Gordon</u> | | | | MD | | | | 9-13-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | |
| Gordon S. Gordon | | | | St. Agnes Hosp 21229 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. CITY OR TOWN COUNTY STATE | | |
| CREMATION | | 9/14/87 | | SECURITY PROCESS CEM. | | CATONSVILLE | | BALTIMORE MD. | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25. DATE REC'D. BY REGISTRAR | | 25a. REGISTRAR'S SIGNATURE | | | | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE | | | | 21229 SEP 14 1987 | | <u>Julia Anderson-Randall</u> | | | | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card to page 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

SEP 14 1987

SEP 14 1987

066765 SEP 25 1987

Item 18a,b, 19a,b, 22a 12-8-87 dw

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

2 5 0 9 2

FOR per med. exam.
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|-----------------|---|---|--|--|--|---|--|--|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST Mary Catherine Goode | | | 2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 22 19 87 | | | 2b HOUR M 10:46 | | | | | | |
| 3 SEX female | | 4 RACE black | | 5 DATE OF BIRTH MONTH DAY YEAR 11 5 1958 | | 6 AGE (IN YEARS) (LAST BIRTHDAY) 28 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va | | | 7b CITIZEN OF WHAT COUNTRY? U S A | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1410 Kingsway Road | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | | 12b KIND OF BUSINESS OR INDUSTRY Social Worker | | | |
| 13a STATE Md | | | 13b COUNTY ✓ | | | 13c CITY OR TOWN Baltimore | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS 1410 Kingsway Road 21218 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Samuel Jerry | | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Coleman | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-70-5847 | | | | 17 INFORMANT ADDRESS Joseph Goode 1410 Kingsway Road | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary pulmonary hypertension complicated by seizure disorder 8552 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiopulmonary arrest following induction of spinal anesthesia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION 11-86 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Pregnancy | | | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Mario F. Golle, Jr., M.D. | | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | DATE SIGNED 9/23/87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. | | | | ADDRESS 111 Penn St. Balto, MD. | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/26/87 | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown MD | | | | | |
| 24 FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | | | ADDRESS West 4300 Wabash Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Pendse | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING", IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED FOR BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP 780
DHMH - 17
(VR A15 ME (5))

080102 SEP 22 61

165717 SEP 16 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 5 6 9 3

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAVID GOODMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 11. 1987 | | 2b. HOUR 6 AM | | | | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR OCT. 28 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | | MD | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINSON HEBREW GERIATRIC CONTROL & HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY HARDWARE | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 108 E. WYOMING ST. 21218 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PINCUS GOODMAN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA PETLOCK | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 072-09-5109 | | 17. INFORMANT MRS. SANDRA A. WENZ | | | 200 CHELL RD. JOPPA, MD 21085 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MULTIPLE INFECTED DECUBITI DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS, PERIPHERAL VASCULAR DISEASE, COPD, ASBESTOSIS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 9/11 19 87 to 9/11 19 87 that (we) last saw the deceased alive on 9/11 19 87 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Estrelita O. Kw. | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/11/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KW. | | | | | | 22e. ADDRESS LEVINSON HEBREW GERIATRIC CONTROL & HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | 23b. DATE SEPT. 14, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PARK | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

102717 239 18 37

067.045 SEP 29 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE REGISTRAR

BASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

FRANCIS

L.

GOODWIN, JR.

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b. HOUR
ESTI- MATED ☐ 9 21 19 87 M

3 SEX

MALE

4 RACE

WHITE

5 DATE OF BIRTH

MAY 22 1925

6 AGE (IN YEARS)

62 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN

IF UNDER 24 HRS

2c. DATE

PRONOUNCED DEAD

MONTH DAY YEAR 9 21 19 87

2d. HOUR

10 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

WASHINGTON, D.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒WIDOWED ☐NEVER MARRIED ☐DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

St. Agnes Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

PRESIDENT

12b. KIND OF BUSINESS OR INDUSTRY

TECH SERV,

INC.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

MONTGOMERY

13c. CITY OR TOWN

ROCKVILLE

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

11520 WEST HILL DRIVE 20852

14. FATHER'S NAME

FRANCIS

MIDDLE

L.

LAST

GOODWIN, SR

15. MOTHER'S MAIDEN NAME

FIRST

IDA

MIDDLE

ELIZABETH

LAST

SABIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

1943-1946

17. INFORMANT

ADDRESS

MARY A. GOODWIN/WIFE/SAME AS 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,

STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion
death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐.

ACTUAL
SIGNATURE

M.D.

TITLE (SPECIFY)

Deputy Chief

MEDICAL EXAMINER

DATE
SIGNED

9-22-87

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

SEPT 25, 1987

23c. NAME OF CEMETERY OR CREMATORY

FT. LINCOLN CEMETERY

23d. LOCATION
(CITY OR TOWN)

BRENTWOOD PRINCE GEORGES MD

COUNTY

STATE

24. FUNERAL DIRECTOR
NAME

FRANCIS J. COLLINS, JR.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901

SEP 28 1987

John Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M-1. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

095042 285001

20% COTTON FIBER

WILSON

1891 05473

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)FIRST
CARLMIDDLE
F.LAST
GOOSMAN

2a. DATE OF DEATH

MONTH
09/30/87DAY
30YEAR
87

2b. HOUR

6:00 am

M

3. SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH DAY YEAR

07/20/03

6. AGE (IN YEARS (LAST BIRTHDAY))

84

YRS.

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

US A

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

ST. AGNES HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

RETIRED SUPERVISOR

12b. KIND OF BUSINESS OR INDUSTRY

B & E

13a. USUAL RESIDENCE (IF NUMBER HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

BALTIMORE

13c. CITY OR TOWN

CATONSVILLE

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

204 BLAKENEY ROAD

21228

14. FATHER'S NAME

LOUIS

MIDDLE

LAST

GOOSMAN

15. MOTHER'S MAIDEN NAME

LOUISE

MIDDLE

LAST

LEISS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

212-05-3997

17. INFORMANT

LILLIAN H. GOOSMAN

ADDRESS

SAME AS # 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Heart Arrest (Found dead in bed)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c) Coronary Artery Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Patient has Severe Coronary Artery Disease

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9-29 1987 to 9-30 1987, that (I) (we) last saw the deceased alive on 9-29 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE

Suhayl K. Alash

DEGREE

M.D.

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

9-30-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SUHAYL KALASH

22e. ADDRESS

3455 WILKINS AVE
Belt MD 21229

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

10/3/87

23c. NAME OF CEMETERY OR CREMATORY

LOUDON PARK

23d. LOCATION

BALTIMORE

COUNTY

MARYLAND

24. FUNERAL DIRECTOR & RUSSELL C. WITZKE FUNERAL HOMES P.A.
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

OCT 05 1987

John F. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and present.

001005 OCT-80

OCT 08 1980

065973 SEP 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|---|---|--|--|---|--|
| 2a DECEASED NAME (TYPE OR PRINT) Charles John Gorman | | | 2b DATE OF DEATH MONTH DAY YEAR SEPT. 14, 1987 | | 2c HOUR 2010 M |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR Jan 27, 1917 | | 6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Quality Engineer | | 12b KIND OF BUSINESS OR INDUSTRY Machine |
| 13a STATE Maryland | | | 13b COUNTY | 13c CITY OR TOWN Baltimore | |
| 14 FATHER'S NAME FIRST MIDDLE LAST John Charles Gorman | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Leitner | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b SOCIAL SECURITY NO. WW II 213-05-6973 | | 17 INFORMANT Mrs. Mildred Gorman same as # 13 | |

| | | |
|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | |
| (b) _____ DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) _____ | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | |
|--|---|---|--|
| 19a DATE OF OPERATION N/A | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from SEPT 13 , 19 87 , to SEPT 14 , 19 87 , that (I) (we) lost saw the deceased alive on SEPT 14 , 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | |
| 22b SIGNATURE Ann S. TRan, MD | | DEGREE M.D. | 22c DATE SIGNED 9-14-87 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Ann S. TRan M.D. | | 22e ADDRESS Union Memorial Hospital | |

| | | | |
|---|----------------------------|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b DATE 9/19/87 | 23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland |
| 24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Road 21214 | | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE SEP 16 1987 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25097

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Laura Gould</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9. 20. 87</i> | | | 2b. HOUR <i>8⁵⁰ A.M.</i> | | | | |
| 3. SEX <i>F</i> | | 4. RACE <i>B 2</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>10 7 1900</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS. | | 6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto City</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE CITY FRANCIS SCOTT KEY CENTER</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE <i>MD.</i> | | | 13b. COUNTY | | 13c. CITY OR TOWN <i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>140 W. LAFAYETTE AVE.</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>UNK.</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNK.</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>UNK.</i> | | | 16b. SOCIAL SECURITY NO. <i>212-32-3166</i> | | 17. INFORMANT ADDRESS <i>ALICE TAYLOR - neice</i> <i>2336 MCCOULLOH ST.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Decubiti</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i> <i>1 day</i> <i>Months</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <i>1.9</i> 19 <i>87</i> , to <i>9.20</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>9.20</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Richard Bennett</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>9.21.87</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard Bennett</i> | | | 22e. ADDRESS <i>5200 Eastern Avenue Balto 21224</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i> | | | 23b. DATE <i>9-22-87</i> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME <i>State Anatomy Board</i> | | | ADDRESS <i>Balto., Md.</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 28 1987</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. H. Davidson</i> | | |

MEDICAL CERTIFICATION

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene prior to burial, entombment, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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UNITED STATES DEPARTMENT OF AGRICULTURE

FOR COTTON



#18, 20, 21a, bcdef, 22a, 87
FOR
1- STATE FilmG632 10/21/87
REGISTRAR
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF ESTI- MATED | | | 2c. DATE PRONOUNCED DEAD | | | 2d. DATE OF DEATH | | |
| Jeffery J. Graboski | | | 9-18-1987 | | | 9-18-1987 | | | 9-18-1987 | | | 9-18-1987 | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR 6 7 53 | | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 34 YRS. | | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | 10. CITY OR TOWN OF DEATH Baltimore | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2066 E. Belvedere 21239 | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Operator-State | | | 12b. KIND OF BUSINESS OR INDUSTRY Lottery | | | 13a. STATE Maryland | | | 13b. COUNTY | | |
| 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 2066 E. Belvedere Ave. 21239 | | | 14. FATHER'S NAME FIRST MIDDLE LAST John J. Graboski | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara E. Glogolia | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 213-60-5826 | | | 17. INFORMANT Nancy C. Graboski | | | 18. ADDRESS 2066 E. Belvedere Ave. | | | 19. CITY OR TOWN Baltimore | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nortriptyline intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

| | | | | | |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9/18 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject ingested nortriptyline | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION CITY OR TOWN COUNTY STATE 2066 E. Belvedere, Balto., Md. | |

| | | | |
|--|--|--|--|
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22b. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i> | | DATE SIGNED 9-19-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. | | ADDRESS 111 Penn Street, Balto., MD 21201 | |

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-22-87 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME Lorraine Funeral Home | | ADDRESS 1401 Belme Rd. Balto. Md. 21236 | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Sander-Rudner</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT, PERMIT, PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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RECEIVED NOTICE



066364 SEP 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|---------|--|--|--|--|---|--|--|--|--------------------------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED MONTH DAY YEAR | | 2b. HOUR | |
| Paul | | Graczyk | | | | | | 9 | | 10 | | 1987 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| M | W | 1 5 03 | | 84 YRS. | | | | | | 9 10 1987 | | 12:35 P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MD. | | U.S.A. | | | | Baltimore City | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | 1802 Eutaw Place | | UNK. | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MD. | | BALTIMORE | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1802 EUTAW PLACE | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| UNK. | | UNK. | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| NO | | 218-01-8797 | | HENRY GOLDBAUM | | Park Manor N/H 1802 Eutaw Pl. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Arteriosclerotic cardiovascular disease with | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| | | | | | | congestive cardiomyopathy | | | | | | | |
| | | | | | | congestive cardiomyopathy | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | | | | | (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | |
| | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that I took charge of the remains described above and on death resulted from: | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | |
| Charles P. Kokes, M.D. | | M.D. Assistant | | 9/11/87 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | |
| Charles P. Kokes, M.D. | | 111 Penn St. | | Balto.MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN) | | COUNTY | | STATE | | | |
| Burial | | 9-22-87 | | Mount Zion Cem. | | Lansdowne | | | | MD | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| W.M. C. March | | F.H. 1101 E. North Ave. | | SEP 21 1987 | | Dorothy R. Rindell | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|---------|---|--|---|--|---|--|---|--|--------------------------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH ESTIMATED | | MONTH DAY YEAR | | 7b. HOUR | |
| ALBERT L. GRAF | | | | | | | | <input checked="" type="checkbox"/> 9-23-87 | | 19 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| Male | White | Aug. 4, 1934 | | 53 | | MONTHS DAYS | | HOURS MIN. | | 9-23-87 | | 6:42P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pennsylvania | | U.S.A. | | <input checked="" type="checkbox"/> WIDOWED | | <input type="checkbox"/> NEVER MARRIED | | Baltimore City | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | University Hospital | | Machine Operator | | Electric Co. | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md. | | Carroll | | Hampstead | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2715 Hanover Pike | | 21074 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Jacob Henry Graf | | Katherine Elizabeth Rohrbaugh | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 215-32-5955 | | Arbadella Graf | | 2715 Hanover Pike | | Hampstead, Md. | | 21074 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Blunt trauma to chest | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | 5:58PM 9-23-87 | | passenger of a pick-up truck impacted by another vehicle subject ejected | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | |
| | | hwy. | | Rt. 30 N. of Old Hanover Rd. Balt. Co., Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | |
| Dennis F. Smyth, M.D. | | Assistant | | 9-24-87 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | |
| Dennis F. Smyth, M.D. | | 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | | |
| Burial | | Sept. 26, 1987 | | Rest Haven Cemetery | | Hanover, Pennsylvania | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| H. J. Schmitt | | Manchester, Md. | | SEP 30 1987 | | Julia Swinson-Padgett | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.2 (CERTAIN PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

Male 10/14/87

U.S.A.

Machine Operator Electric No.

No. Council

Jacob Henry

No. 715-3-7077

715-3-7077 A female Gray hair, No. 2107



Bureau 26, 1907 West Haven Cemetery

Manchester, N.H.

SEP 20 1987

065899 SEP 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doris Green | | | 7a. DATE OF DEATH MONTH DAY YEAR 9 - 10-87 | | 7b. HOUR 10⁵⁴ P.M. |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 3- 27- 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Donald Cole | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Brown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 217-22-5282 | | 17. INFORMANT ADDRESS Bernice Cole 124 N. Amity St | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) hypertension | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Small cell carcinoma lung | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6/24 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE CD Kearney MD | | | | 22c. DATE SIGNED 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTOPHER D. KEARNEY | | | | 22e. ADDRESS 700 WASH BLVD - BALT | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-16-87 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balt Co. MD | | 24. FUNERAL DIRECTOR NAME Irvin Carroll | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1987 | |
| 25b. REGISTRAR'S SIGNATURE Julia Gordon-Kendall | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The physician must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at office.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|---|--------------------------|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HILDA C. GREEN | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/6/87 | | 2b. HOUR 11 AM | | | | | | |
| 3. SEX Female | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 6 4 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Bow Secovers Hosp. | | 12a. USUAL OCCUPATION (TYPE OF BUSINESS OR MOST OF WORKING LIFE) CATERER | | 12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY Balt | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3409 Lynnhaven Ave 21230 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes BAILEY | | 16. INFORM. MRS. BALTIMORE, MO. DR. ODESSA W. DYSON 3409 LYNNEHAVEN | | | | | | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO. | | 18b. SOCIAL SECURITY NO. 216-09-6460 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiovascular accident | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) coronary atherosclerosis | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a deep venous thrombosis - DVT | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/2 19 87 to 9/6 19 87 , that (I) (we) lost saw the deceased alive on 8/6 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE James Evans MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/6/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Evans MD | | | | 22e. ADDRESS 700 Washington Blvd, Balto, Md 21230 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/11/1987 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL HOME (NAME AND ADDRESS) NUYTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY, BALTO, MD, 21216 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 10 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randolph | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return carbon papers, pages 1 and 2, to the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MARY MIDDLE A. LAST GREEN | | MONTH 9 - DAY 12 - YEAR 87 | | 4:15 A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS (LAST BIRTHDAY)) | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| F | B | 8-31-32 | 55 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Baltimore MD | USA | | Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | Baltimore Naval | | Wine Merchant | | at home |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS, ZIP CODE | |
| MD | | Baltimore | | 510 N. Calver St 21223 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | |
| Alfred W. Dixon | Carrie Williams | | 16b. SOCIAL SECURITY NO. 213-26 7598 | | |
| 17. INFORMANT | | ADDRESS | | | |
| W. H. Gaven | | 510 N. Calver St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute Bacterial Endocarditis | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) End Stage Renal Disease | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Upper GI bleed 2° gastritis & duodenal ulcer | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | | |
| 21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/15/87 to 9/12/87, that (1) (we) lost the deceased alive on 9/12/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (I) did not view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | 22c. DATE SIGNED | | |
| J. BELTRAN | | MD | 9/12/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| J. BELTRAN | | 1940 W. BALTIMORE ST 21223 | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 9-16-87 | St. Agnes | Baltimore, MD | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Marshall P. Hayes 638 N. Gilman St. | | SEP 15 1987 | | Julia Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|----------------------------|-----------------------------------|------------------|--|
| DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| | | Mary | L. | Green | Sept | 17 | 07 | 11:26 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| F | B | MONTH DAY YEAR 10 14 34 | | 52 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| LUNenburg VA | USA | | | Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore City | The Union Memorial Hospital | | | Housewife | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| MD. | | Balto. | | 1516 HOFFMAN 21243 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST James Taylor | | FIRST MIDDLE LAST Louetta MASON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| NO | | 212-40-2471 | | ROSA L. Lee P.O. Box 1048 Victoria Virginia | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cerebral Edema | | | | | | | | | 30 |
| DUE TO, OR AS A CONSEQUENCE OF (b) Surgical Removal of tumor | | | | | | | | | 60 |
| DUE TO, OR AS A CONSEQUENCE OF (c) metastatic Squamous Cell Carcinoma | | | | | | | | | 2-3 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| None | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 9/14 + 9/15/87 | Intracranial tumor / Cerebral Edema | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/14 to 9/17, 19 87, that (I) (we) last saw the deceased alive on 9/17, 19 87, and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | |
| Brent C. Birely | | | MD | | | | 9/17/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| Brent C. Birely, M.D. | | | | The Union Memorial Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | 23e. COUNTY STATE | | |
| Bucial | 9-23-87 | Family Plot | | | Lunenburg Co. | | VA | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| W.C. Brown 1206-831 North Ave | | | | SEP 18 1987 | | Julia Anderson-Randall | | | |

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100% COTTON FIBER

MADE IN U.S.A.

066146 SEP 18 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MORTON MIDDLE ELMER LAST GREENBERG | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 14, 1987 | | 2b. HOUR AM PM 5:18 M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR APR. 7, 1931 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3722 CLARINTH RD. | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TYPIST | | 12b. KIND OF BUSINESS OR INDUSTRY CITY OF BALTO. | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | |
| 14. FATHER'S NAME FIRST LOUIS MIDDLE GREENBERG LAST | | 15. MOTHER'S MAIDEN NAME FIRST IDA MIDDLE ALTER LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. KOREAN 212-28-4509 | | 17. INFORMANT MRS. MYRNA GREENBERG 3722 CLARINTH RD. BALTO., MD 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST AT HOME DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN DUE TO, OR AS A CONSEQUENCE OF (c) UNKNOWN | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a END STAGE RENAL DISEASE - STABLE ON CHRONIC MAINTENANCE HEMODIALYSIS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 31, 1983, to SEPT 13, 1987, that (I) (we) lost saw the deceased alive on SEPTEMBER 10, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John Josselson | | DEGREE MD | | 22c. DATE SIGNED 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN JOSSELSO, M.D. | | 22e. ADDRESS 11 S. PACA ST. BALTO., MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 16, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY MD FREE STATE POST 167 JWW ROSEDALE BALTO. MD | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD, BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | | |
| | | 25b. REGISTRAR'S SIGNATURE Julia L. Anderson-Rublee | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25 706

REG. NO.

Item 13 per phone
FOR STATE REGISTRAR 9/18/87 ID

| | | | | | | | |
|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST "Keith" BB Greenidge | | | 2a. DATE OF DEATH MONTH DAY YEAR 6/18/87 | | | 2b. HOUR 906 ^A | |
| 3. SEX male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 6 17 87 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 3 7 16 | | IF UNDER 1 YEAR IF UNDER 74 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 13a. STATE MD | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Greenidge Charlene | | 13e. STREET ADDRESS / ZIP CODE 104 SUMMAR CT. 21207 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Severe Prematurity

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | |
|---|---|---|--|
| 19a. DATE OF OPERATION N/A | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) N/A | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 17</u> , 19 <u>87</u> , to <u>June 18</u> , 19 <u>87</u> , that (I) (we) lost <u>saw the deceased alive on above</u> , (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE S. McWath | | DEGREE MD | 22c. DATE SIGNED 6/18/87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. McWath | | 22e. ADDRESS Sinai Hospital | |

| | | | |
|---|----------------------|--|--|
| 23a. BURIAL (CREMATION) REMOVAL (SPECIFY) CREMATION | 23b. DATE 8-31-87 | 23c. NAME OF CEMETERY OR CREMATORY Sinai Hospital | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD |
| 24. FUNERAL DIRECTOR NAME Sinai Hospital | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | |
| ADDRESS 2401 W. BELUCRE AVE | | 25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SHARON GRISER | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 05 87 | | | 2b. HOUR 12:15 AM | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 12 07 52 | | 6. AGE (IN YEARS LAST BIRTHDAY) 34 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL McKINNEY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY FLEETS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-66-3868 | | 17. INFORMANT ADDRESS VERA ROBINSON 2014 PARK AVENUE 21217 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MITRAL VALVE INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) ENDOCARDITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31 1987 , to 9/5 1987 , that (I) (we) last saw the deceased alive on 9/5/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE David A. Flick | | | | DEGREE MD | | 22c. DATE SIGNED 9/5/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID A. FLICK | | | | 22e. ADDRESS 22 SOUTH GREEN ST BALT. MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/9/87 | | 23c. NAME OF CEMETERY OR CREMATORY EASTVIEW MEM. PK. CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE DUNDAL MD | |
| 24. FUNERAL DIRECTOR WM. C. MARCH F/H INC. 1101 E. NORTH AVE. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1987 | | 25b. REGISTRAR'S SIGNATURE David A. Flick | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, the medical examiner must be notified at once.

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1. The first part of the report is a description of the
 2. The second part is a description of the
 3. The third part is a description of the
 4. The fourth part is a description of the
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 100. The hundredth part is a description of the



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

25708

| | | | | | | | | | |
|---|--|---|---|--|---|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) NELLIE GRIFFIN | | | 2a DATE OF DEATH MONTH DAY YEAR 9-18-87 | | | 2b HOUR 958 A M | | | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5 DATE OF BIRTH MONTH DAY YEAR 8 22 26 | | 6 AGE (IN YEARS LAST BIRTHDAY) 61 | | 7a IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS | |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA | | 7c CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PART-TIME | | 12b KIND OF BUSINESS OR INDUSTRY NURSE | |
| 13a STATE MD | | | 13b COUNTY BALTO. | | 13c CITY OR TOWN BALTO. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH SMITH | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH BYRANT | | | 16 STREET ADDRESS / ZIP CODE 2007 E. OLIVER STREET 21213 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b SOCIAL SECURITY NO. 257-34-3879 | | 17 INFORMANT ADDRESS HERMAN GRIFFIN 2007 E. OLIVER STREET | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFRACTION DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITIS | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (the hospital) attended the deceased from SEPTEMBER 18 87 to SEPTEMBER 18 87 that (I) (we) last saw the deceased alive on SEPTEMBER 18 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | | | |
| 22b SIGNATURE Kenneth D. Byrly MD | | | | | | DEGREE | | 22c DATE SIGNED 9/18/87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth D. Byrly MD | | | | | | 22e ADDRESS CHURCH HOSPITAL CORP. 100 N. BROADWAY BALTIMORE, MD. 21231 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b DATE 9/23/87 | | 23c NAME OF CEMETERY OR CREMATORY KING MEMORIAL PARK | | 23d LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN MD | | |
| 24 FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC | | | | | | ADDRESS 1101 E NORTH AVENUE | | 25a DATE REC'D. BY REGISTRAR SEP 22 1987 | |
| | | | | | | 25b REGISTRAR'S SIGNATURE William C. March | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

BP

SEP 24 1981

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SEP 28 1981

065842 SEP 16 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25709

| | | | | | |
|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) REBECCA JANE GRIFFIN | | | 2a. DATE OF DEATH MONTH 09 DAY 07 YEAR 87 | | 2b. HOUR 3:35 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH Sept. DAY 22 YEAR 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Balto. 13c. CITY OR TOWN Balto. | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 744 Armcliffe road 21221 |
| 14. FATHER'S NAME FIRST George MIDDLE LAST Gosman | | 15. MOTHER'S MAIDEN NAME FIRST Edith MIDDLE LAST Hynson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. 214-28-1652 | | 17. INFORMANT ADDRESS William Griffin Sr. 744 Armcliffe Road 21221 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Lt sided Stroke DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Lt lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma Lt upper lobe | | | | | |
| 19a. DATE OF OPERATION 9/14/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Lt lung | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/3/87 to 9/7/87 , that (we) last saw the deceased alive on 9/7/87 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Gopal Guruswamy | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/7/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GOPAL GURUSWAMY | | 22e. ADDRESS GSH | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/11/87 | 23c. NAME OF CEMETERY OR CREMATORY Church Hill Cemetery | | 23d. LOCATION CITY OR TOWN Church Hill COUNTY Queen Anne STATE Md. |
| 24. FUNERAL DIRECTOR NAME Connolly Funeral Home | | ADDRESS 300 Mace Ave. 21221 | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | 25b. REGISTRAR'S SIGNATURE Lelia Deaton-Randall |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examination must be completed before burial or cremation.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10

Robert James Griffin



Director of State

State of New York

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN GROBANI | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 24 87 | | | 2b. HOUR 9:20 AM | | | | |
| 3. SEX Male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 05 - 10 - 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levindale Nsg HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CANTOR | | 12b. KIND OF BUSINESS OR INDUSTRY RELIGION | | |
| 13a. STATE Md | | | | | 13b. CITY OR TOWN BALTO. | | 13c. INSIDE CITY LIMITED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE 30 MARYLAND AVE 21205 | |
| 14. FATHER'S NAME ISRAEL GROBANI | | | | | 15. MOTHER'S MAIDEN NAME FANNIE UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 216-32-7537 | | 17. INFORMANT MRS. MIRIAM GROBANI 30 MARYLAND AVE. BALTO., MD 21208 | | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) INFECTED SACRAL DEWIDITIS DUE TO, OR AS A CONSEQUENCE OF (c) END-STAGE PARKINSON'S DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 1 mo 3 yr | |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 9-9, 19 87, to 9-24, 19 87, that (1) (we) last saw the deceased alive on 9-24, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE A. J. Lucco | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-24-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. Lucco | | | | 22e. ADDRESS 2434 W. BELVEDERE AVE. BALTO 21215 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT. 27, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM | | 23d. LOCATION BALTIMORE MARYLAND STATE | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1987 | | 25b. REGISTRAR'S SIGNATURE J. A. [Signature] | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. They please reverify page 3 of this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, brother traumatic event, then the death certificate must be notified and filed with the State Dept. of Health and Mental Hygiene.

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U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

[Faint, mostly illegible text, possibly a letter or report, covering the majority of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME FIRST MIDDLE LAST (Type or print) DELMERS J. GROSS | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-21-87 | | 2b. HOUR P M 12:00 P |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 1 5 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md | | 13c. COUNTY Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 3916 Norfolk Ave 21216 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert H. Gross | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Gwynn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-09-1775 | | 17. INFORMANT ADDRESS Julia Gross 3916 Norfolk Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Shock. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b). Sepsis. DUE TO, OR AS A CONSEQUENCE OF (c). | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Respiratory failure - Renal failure - Metastatic Cancer | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 08/30 19 87 to 09/21 19 87 that (I) (we) last saw the deceased alive on 9/21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE BICH T. DUONG | | DEGREE M.D. | | 22c. DATE SIGNED 9-21-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH T. DUONG | | 22e. ADDRESS LIBERTY MEDICAL CENTER | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/25/87 | 23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25712

FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALENE P. GROVE | | | 1a. DATE OF DEATH MONTH DAY YEAR 9/14/87 9-14-87 8-55A | | |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 11/1/1883 | 6. AGE (IN YEARS LAST BIRTHDAY) 103 | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MED. CENTER INC | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER | 12b. KIND OF BUSINESS OR INDUSTRY PVT. FAMILY | |
| 13a. STATE MARYLAND | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 2427 McCulloh STREET BALTO. MD 21217 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GILBERT | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PETTIE PEGGY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO. | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT MARYLAND 2/2/77 2427 McCulloh STREET, BALTIMORE, | |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonia with

DUE TO, OR AS A CONSEQUENCE OF

possible sepsis

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Chronic obstructive lung diseases.

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22. I certify that (I) (this hospital) attended the deceased from 9/14/87 to 9/19/87 that (I) (we) last saw the deceased alive on 9/14/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|-------------|---|-----------------------------|
| 23a. SIGNATURE R-M-Shah M.D. | 23b. DEGREE | 23c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 23d. DATE SIGNED 9/14/87 |
| 24a. PHYSICIAN'S NAME (TYPE OR PRINT) R-M-SHAH, M.D. | | 24b. ADDRESS LIBERTY Medical Center INC 2600 LIBERTY Ht AVE Baltimore, MD. | |

| | | | |
|---|------------------------|---|---|
| 25a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 25b. DATE 9/19/1987 | 25c. NAME OF CEMETERY OR CREMATORY MD. NATIONAL MEM. PK. | 25d. LOCATION CITY OR TOWN COUNTY STATE LAUREL, MD. |
| 26. FUNERAL HOME, ADDRESS NUTTER FUNERAL HOMES, INC, 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | 27a. DATE REC'D. BY REGISTRAR SEP 17 1987 | 27b. REGISTRAR'S SIGNATURE Julia Davidson-Pedersen |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. These authorities, pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above only report to other interested agent. The medical examiner must be notified of any change.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) BABYX Garrett BOYX Roland GROVE | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 12, 1987 | | | 2b. HOUR 5:06 M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1987 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ----- | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Harford 13c. CITY OR TOWN Fallston 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 702 Reckord Rd. 21047 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dale Grove | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beth Garrett | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ----- | | 16b. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Mr. Dale Grove, Fallston, Md. 21047 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>meconium aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe perinatal asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 minutes</u> <u>2-3 days</u> <u>2-3 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-11</u> 19 <u>87</u> to <u>9-12</u> 19 <u>87</u> , that (I) (e) last saw the deceased alive on <u>9-12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Elizabeth C. Engle</u> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED <u>9-12-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Elizabeth C. Engle</u> | | | | | 22e. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u> <u>600 N WOLFE ST. BALTO. 21205, MD.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>9-16-1987</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gar.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bel Air Harford Md.</u> | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <u>E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087</u> | | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 18 1987</u> | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Bender-Randall</u> | | | | |

MEDICAL CERTIFICATION

Medical Examination and Cause of Death

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

228 50 32

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed, and the deceased has been buried, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or unusual cause of death, a medical examination and cause of death must be filed.

088450 SEP 35 81

CRUISE: 88-BELN

558 20 35

064981 SEP -9 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25714

| | | | | | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|---|--|--------------------------|--|--|-------------------|------------------|--|---|--|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | 3. MONTH DAY YEAR | | | 2b. HOUR | | | | | | | |
| William | | | Grover | | | 9 | | | 5 19 87 | | | M | | | | | | | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | |
| Male | | White | | June 14/ '25 | | 62 YRS. | | MONTHS DAYS | | HOURS MIN. | | 9 5 19 87 | | 11:40 M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore City MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | | | Church Home Hospital | | | | Railroad | | | | --- | | | | | | | |
| 13a. STATE | | | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | | | | | | | | | | | ---- | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1924 Eastern Ave. - 21231 | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Frank | | | | | | Grover | | | | | | Mabel Sullivan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT ADDRESS | | | | | | | |
| yes | | | | | | WWII | | | | | | 217-14-9432 Earl Schwartz 522 S. Broadway-21231 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | |
| Carcinoma of throat | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| 22b. Actual Signature: <u>Margarita A. Korell</u> TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 9/8/87 | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St. Balot. MD. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | | | 9/9/87 | | | | Crownsville VA | | | | Anne Arundel Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Lilly & Zeiler, Inc. 1901 Eastern Ave. 21231 | | | | | | | | | | | | SEP 8 1987 | | | | <u>Anita Davidson-Lindner</u> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXEMPTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MDHMH - 17
(VR A15 ME (5))

90% COTTON LINES

11/10/50

11/10/50



FOR
STATE
REGISTRAR

STATE OF MARYLAND 87
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25715

| | | | | | | | | | | | | | |
|--|--|---|--|---|----------------|---|--|--|-------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST LUCY | | MIDDLE A. | LAST GROVES | | 2a. DATE OF DEATH MONTH DAY YEAR 9 26 87 | | 2b. HOUR 10-15 | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 26, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 7b. HOUR | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Perry Hall | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4301 Chapel Rd. 21128 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Beeman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Garlitz | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | | | | | |
| 16b. SOCIAL SECURITY NO. 216-30-7196 | | 17. INFORMANT ? Mrs. Edna F. Benfield Same as #13e | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF UROSEPSIS (b) DEHYDRATION DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. BILATERAL PNEUMONIA, ATRIAL FIB. HCD, HEND. SENILE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/18 1987, to 9/26 1987, that (I) (we) lost saw the deceased alive on 9/26 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Embacher Woreta M.D. | | DEGREE | | 22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22d. DATE SIGNED 9/26/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-29-87 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 | | | | | | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodell | |

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SEP 28 1907

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065312 SEP

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|--|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ALBERT GUTIN</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>09 05 87</i> | | | | 2b. HOUR <i>0725</i> M. | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>11 09 29</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>57</i> | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UMMS 225 Greene</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>County Schools</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13a. COUNTY <i>AA</i> | | 13c. CITY OR TOWN <i>Arnold</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <i>4020 Manor Rd. 21012</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Fanny Radishofsky</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>190907200</i> | | 17. INFORMANT <i>Mrs. Anna Gutin</i> | | ADDRESS <i>420 Manor Rd. Arnold, Md. 21012</i> | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Cardiopulmonary Arrest*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) *Ischemic Cardiomyopathy*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/27</i> , 19 <i>87</i> , to <i>9/5</i> , 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>9/5</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE <i>MD</i> | | 22c. DATE SIGNED <i>9/7/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alfonso</i> | | | | 22e. ADDRESS <i>225 Greene St Balto</i> | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>9-06-1987</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Annapolis A.A. Md.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>ROBERT S. BARRANCO</i> ADDRESS <i>SEVERNA PARK, MD. 21146</i> | | | | 25. DATE REC'D BY REGISTRAR <i>SEP 08 1987</i> | | | |
| | | | | 26. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the Department of Health and Mental Hygiene prior to burial, cremation, or other disposition. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

082315 SEP 14 83

ROBERT S. BARRANCO
SEVERNA PARK MD 21146

065598 SEP 15 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 5 7 1 7

1- FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
RICHARD Elmer

HAHN

2a DATE OF DEATH MONTH DAY YEAR
SEPTEMBER 7, 19872b HOUR
9:13 M3 SEX
male4 RACE
white5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 31, 19216 AGE (IN YEARS LAST BIRTHDAY)
65 YRSIF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.7a BIRTHPLACE (STATE OR FOREIGN
COUNTRY)
Pennsylvania7b CITIZEN OF WHAT COUNTRY?
USA8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD.10 CITY OR TOWN OF DEATH
BALTIMORE11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
elect. engineer12b KIND OF BUSINESS OR
INDUSTRY
truck13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE

Maryland

13b COUNTY
Washington13c CITY OR TOWN
Hagerstown13d INSIDE CITY LIMITS?
YES ☐ NO ☐13e STREET ADDRESS / ZIP CODE
313 Dellwyn Drive 2174014 FATHER'S NAME
FIRST MIDDLE LAST
Arthur Charles

Hahn

15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie

Smith

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes(IF YES, GIVE WAR OR DATES)
1943-4616b SOCIAL SECURITY NO.
219 12 145817 INFORMANT
ADDRESS
E. Ruth Hahn, Hagerstown, Md.18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiogenic shock and cardiac arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 hrs

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Acute Ventricular septal defect

2 days

DUE TO, OR AS A CONSEQUENCE OF

(c) Myocardial infarction

2 days

PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION
9/7/8719b CONDITION FOR WHICH OPERATION WAS PERFORMED
Acute Ventricular Septal defect20a AUTOPSY?
YES ☒ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from on 9/6/87, 1987, to 9/7/87, 1987, that (I) (we) last saw the deceased alive on 9/7/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.

22b. SIGNATURE
Fady Sanno

DEGREE

M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

9/7/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

FADY SANN

22e. ADDRESS

JOHNS HOPKINS HOSPITAL
BALTIMORE MD 2120523a BURIAL, CREMATION, REMOVAL
(SPECIFY)

burial

23b. DATE
Sept. 10, 198723c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery23d. LOCATION
CITY OR TOWN COUNTY STATE

Hagerstown, Wash., Maryland

24 FUNERAL DIRECTOR
NAME

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

25a DATE REC'D. BY REGISTRAR

SEP 14 1987

25b. REGISTRAR'S SIGNATURE

Julia Anderson-Randall

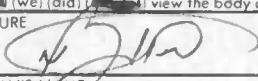

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Page 4 should be retained by the funeral director. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to cremation, entombment, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner must be notified.
RELEASED AS NON-MEDICAL RECORD BY DR. DIXON PER MR. LAWYER

0 6 2 2 2 0 8 2 9 1 2 8 1

DHMH - 16 60M 7/84
(VRA 15, 4)

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7

| | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) 087 SIDNEY B. HAISLETT | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 22 87 2b. HOUR 1:18 PM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR FEB 9 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED CENTER | | | | 12a. USUAL OCCUPATION (TYPE OR WORK FORM OR MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2953 Yorkway 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sidney A. Haislett | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Shifflett | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean | | 17. INFORMANT ADDRESS Gertrude Haislett 2953 Yorkway 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) End stage renal disease | | | | | | | | | |
| 19a. DATE OF OPERATION 9/21/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal failure | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 9/10 , 19 87 , to 9/22 , 19 87 , that (we) last saw the deceased alive on 9/22 , 19 87 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE  | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9/22/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. BADDOURA | | | | | 22e. ADDRESS FSK HOSPITAL, EASTERN AVE, Balt, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/25/87 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Maryland | | |
| 24. FUNERAL DIRECTOR Connelly Funeral Home of Dundalk ADDRESS 21222 | | | | | | 25a. DATE RECD. BY REGISTRAR SEP 9 5 1987 | | 25b. REGISTRAR'S SIGNATURE  | |

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SEP 9 1981

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE M. HALL | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-14-87 | | 2b. HOUR MIN. 1:15 AM | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 03-02-20 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 67 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Principal | | 12b. KIND OF BUSINESS OR INDUSTRY School System | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY VISA 140 | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dewey S. Parker | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Roberts | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 214-40-5196 | |
| 17. INFORMANT ADDRESS Melvin Parker 1268 Dunbar Ave. Annapolis, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-14-87 to 9-14-87 , that (I) (we) last saw the deceased alive on 9-14-87 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE CJ Nesbitt MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CJ NESBITT | | 22e. ADDRESS Mercy Hospital 301 St Paul Pl Balt 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY Security Process | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland | |
| 24. FUNERAL DIRECTOR NAME Nutter Funeral Homes, Inc 2501 Gwynns Falls Pkwy | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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067566 OCT-5 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25720

| | | | | | |
|---|-----------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Jane M. Hancock | | 9/30/87 | | 4:45 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | |
| Female | Caucasian | 8/10/22 | | 65 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8. MARried <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Pennsylvania | | U.S.A. | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | Union Memorial Hospital | | Clerk | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS / ZIP CODE | |
| Maryland | | Eldersburg | | 2305 Lake Circle Drive 21784 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| Carl Whitman Shatzner | | Ruth Wagner | | 219-18-4582 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 17b. INFORMANT | | 17c. ADDRESS | |
| No | | Mr. Ralph Hancock | | 2305 Lake Circle Drive Eldersburg Maryland 21784 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>fulminant sepsis</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>End-stage metastatic breast cancer</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Disseminated intravascular coagulation</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| NA | | NA | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| NA | | 9/19/87 | | NA | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| NA | | NA | | NA | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/19/87</u> to <u>9/30/87</u> , that (I) (we) lost <u>9/30</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | |
| Nicholas J. Kohlepurtt | | | | 9/30/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| Nicholas Kohlepurtt MD. | | | | Union Memorial Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 10/03/87 | | Crest Lawn Memorial | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Loring Byers Funeral Directors, Inc | | OCT - 2 1987 | | Julia Benson-Randall | |
| 8728 Liberty Road | | Randallstown Maryland | | 21133 | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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066766 SEP 25 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RANDOLPH L. HANDY | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 18 87 | | | 2b. HOUR 2015 M | |
| 3 SEX M | | 4 RACE B 2 | | 5. DATE OF BIRTH MONTH DAY YEAR 11 19 25 | | 6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALT CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALT CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Fireman | |

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3913 DUVALL AVE 21216 | |
| 13a. STATE MD | | 13b. COUNTY BAL | | 13c. CITY OR TOWN BALT | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JESSIE HANDY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Handy | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) W.W. 2 | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1/44 3/46 19-10-8140 | | 17 INFORMANT ADDRESS Yvonne Handy 3913 Duvall Ave. 21216 | | | |

| | | | |
|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Intra cerebral bleed | | 7 da | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/11 19 87 , to 9/18 19 87 , that (I) (we) last saw the deceased alive on 9/18 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Roxanne S. Donovan | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/18/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roxanne S. Donovan | | | | 22e. ADDRESS Sinai Hosp. | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/24/87 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md. | |
| 24 FUNERAL DIRECTOR'S NAME CHARLES A RICE FUNERAL SERVICE, P.A 1300 EUTAW PLACE | | | | 25a. DATE REC'D. BY REGISTRAR SEP 24 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Dondor-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|-----------------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| JAMES EDWARD HANE, JR. | | | 9 3 87 | | | 3:10 P.M. | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | | |
| MALE | WHITE | MONTH 5 DAY 19 YEAR 06 | 81 YRS. | | | IF UNDER 24 HRS. | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. CITIZEN OF WHAT COUNTRY? | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| MARYLAND | U.S.A. | | Baltimore City MD. | | | | | | |
| 12. CITY OR TOWN OF DEATH | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | St. Agnes Hospital | | | SALES REP. | | | LINEN THREAD CO. | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 17. INSIDE CITY LIMITS? | | | 18. STREET ADDRESS | | | |
| 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN CATONSVILLE | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 711 MAIDEN CHOICE LANE 21228 | | | |
| 19. FATHER'S NAME | | | 20. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST JAMES EDWARD HANE, SR. | | | FIRST MIDDLE LAST CATHERINE HOEHN | | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 22. SOCIAL SECURITY NO. | | | 23. INFORMANT ADDRESS | | | |
| NO | | | 212-03-8315 | | | AUDREY B. HANE 711 MAIDEN CHOICE LANE 21228 | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 26. DATE OF OPERATION | | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 28. AUTOPSY? | | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 33. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 34. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM, ETC.) | | | 35. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 36. I certify that (I) (this hospital) attended the deceased from 7-26 19 87, to 9-3 19 87, that (I) (we) last saw the decedent alive on 9-3-19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 37. SIGNATURE | | | | | | 38. DEGREE | | 39. DATE SIGNED | |
| William Russell MD | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 9/3/87 | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 41. ADDRESS | | | |
| William Russell MD | | | | | | 711 Maiden Choice Lane Balt 21228 | | | |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 43. DATE | | 44. NAME OF CEMETERY OR CREMATORY | | 45. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 9/8/87 | | NEW CATHEDRAL CEM. | | BALTIMORE MARYLAND | | |
| 46. FUNERAL DIRECTOR NAME | | | 47. ADDRESS | | | 48. DATE REC'D. BY REGISTRAR | | | |
| HUBBARD FUNERAL HOME, INC. | | | 4107 WILKENS AVENUE | | | SEP 08 1987 | | | |
| | | | | | | 49. REGISTRAR'S SIGNATURE | | | |
| | | | | | | John Jordan-Rodell | | | |

BP

004249 26-932

004249 26-932

067289 OCT - 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25723

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Leon MIDDLE R. LAST Hannan
2a. DATE OF DEATH MONTH 9 DAY 26 YEAR 87 2b. HOUR 4 20 PM

3. SEX M Male 4. RACE White 5. DATE OF BIRTH MONTH 10 DAY 15 YEAR 1895 6. AGE (IN YEARS LAST BIRTHDAY) 89 91 YRS. IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physical Therapist 12b. KIND OF BUSINESS OR INDUSTRY Medical

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 349 Homeland Southway 21212

14. FATHER'S NAME FIRST Joseph MIDDLE Robert LAST Hannan 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Alice LAST McKnight

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWI 16b. SOCIAL SECURITY NO. 217-03-1376 17. INFORMANT ADDRESS Robert Hannan 903 East Wind Road 21204

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cardio pulmonary Arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days
DUE TO, OR AS A CONSEQUENCE OF: (b). Left Cerebrovascular Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF: (c).

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Intestinal Obstruction -

19a. DATE OF OPERATION 9/29/87 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ A) WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22. I certify that (I) (this hospital) attended the deceased from 9/26/87 to 9/26/87, that (I) (we) last saw the deceased alive on 9/26/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Adnan Sunji DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c. DATE SIGNED 9/26/87 7:00 PM

22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADNAN SUNJI MD. 22e. ADDRESS Good Samaritan Hospital 323 2200

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 9-29-87 23c. NAME OF CEMETERY OR CREMATORY Meadowridge 23d. LOCATION CITY OR TOWN Elkridge COUNTY Balto STATE Md

24. FUNERAL DIRECTOR (NAME) Mitchell-Wiedefeld Home ADDRESS 6500 York Road 21212 25a. DATE REC'D. BY REGISTRAR SEP 30 1987 25b. REGISTRAR'S SIGNATURE W. J. Davidson-Randall

BP

087500 OCT-187

| | | | |
|---------------------------------------|--|-------------|--|
| 1. Name of the person or organization | | 2. Address | |
| 3. City | | 4. State | |
| 5. Zip | | 6. Country | |
| 7. Telephone | | 8. Fax | |
| 9. E-mail | | 10. Other | |
| 11. Date | | 12. Time | |
| 13. Subject | | 14. Remarks | |
| 15. Signature | | 16. Stamp | |
| 17. Initials | | 18. Date | |
| 19. Time | | 20. Other | |
| 21. Name | | 22. Address | |
| 23. City | | 24. State | |
| 25. Zip | | 26. Country | |
| 27. Telephone | | 28. Fax | |
| 29. E-mail | | 30. Other | |
| 31. Date | | 32. Time | |
| 33. Subject | | 34. Remarks | |
| 35. Signature | | 36. Stamp | |
| 37. Initials | | 38. Date | |
| 39. Time | | 40. Other | |
| 41. Name | | 42. Address | |
| 43. City | | 44. State | |
| 45. Zip | | 46. Country | |
| 47. Telephone | | 48. Fax | |
| 49. E-mail | | 50. Other | |
| 51. Date | | 52. Time | |
| 53. Subject | | 54. Remarks | |
| 55. Signature | | 56. Stamp | |
| 57. Initials | | 58. Date | |
| 59. Time | | 60. Other | |
| 61. Name | | 62. Address | |
| 63. City | | 64. State | |
| 65. Zip | | 66. Country | |
| 67. Telephone | | 68. Fax | |
| 69. E-mail | | 70. Other | |
| 71. Date | | 72. Time | |
| 73. Subject | | 74. Remarks | |
| 75. Signature | | 76. Stamp | |
| 77. Initials | | 78. Date | |
| 79. Time | | 80. Other | |
| 81. Name | | 82. Address | |
| 83. City | | 84. State | |
| 85. Zip | | 86. Country | |
| 87. Telephone | | 88. Fax | |
| 89. E-mail | | 90. Other | |
| 91. Date | | 92. Time | |
| 93. Subject | | 94. Remarks | |
| 95. Signature | | 96. Stamp | |
| 97. Initials | | 98. Date | |
| 99. Time | | 100. Other | |

SEP 30 1987

067575 OCT-5-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 2572

REG. NO.

| | | | | | | | | |
|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RUBY I. HANNON | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-27-87 | | | 2b. HOUR 11 ¹⁵ AM | | |
| 3. SEX F | | | 4. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | | 5. DATE OF BIRTH MONTH DAY YEAR 6 12 11 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Cata Manor | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Bacon | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Dirre | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 579-07-1661 | | | 17. INFORMANT Kathleen Klipa 3033 Guilford Ave. 21218 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular thrombosis, extensive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease, advanced | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes Mellitus, I | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 9/27/87 to 9/27/87, that (1) (we) last saw the deceased alive on 9/27/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (certification valid not view the body after death). | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert J. Levickas | | | | | | 22c. DATE SIGNED 9/27/87 | | 22d. ADDRESS 5404 East Drive (21227) |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 9/30/87 | | | 23c. NAME OF CEMETERY OR CREMATORY Security Process Crem. | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | | 25a. DATE REC'D. BY REGISTRAR OCT-2 1987 | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

067272 OCT-287



WILSON'S COLLOID

WILSON'S COLLOID

067823 OCT 17 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25725

| | | | | | | | | | | | | | | | |
|---|--|---------|-------------------|---|--|------------------------------------|--|--|------------------|---------------------|--|---|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | X MONTH DAY YEAR | | | 2b. HOUR | | | |
| Brenda | | | M. | | | Harcum | | | 9/ 30/ 87 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| FEMALE | | BLACK | | 3 17 41 | | 46 YRS | | MONTHS DAYS | | HOURS MIN | | 9/ 30/ 87 | | 1:50 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD | | | | USA | | | | | | | | Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | 1424 N. Chester St. | | | | N/A | | | | N/A | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 13f. ZIP CODE | | | |
| MD | | | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1424 N. CHESTER | | 21213 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | |
| JAMES | | | | HARCUM | | | | MARY SHAW | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| (YES, NO, OR UNKNOWN) | | | | (IF YES, GIVE WAR OR DATES) | | | | 214-38-9221 | | | | MARY PRICE 2108 E. HOFMAN 21213 | | | |
| NO | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | |
| <u>Obesity</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| <i>Dennis F. Smyth</i> | | | | Assistant | | | | 10/1/87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Dennis F. Smyth, M.D., | | | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| BURIAL | | | | 10/6/87 | | BALTIMORE CEMETERY | | | | BALTIMORE | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| WM. C. MARCH F/H INC. | | | | OCT 05 1987 | | | | <i>Julia Davidson-Randall</i> | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-13. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

001023 OCT-781

UNDA WIKI-YAITH

19814 MONT 2 2008



065330 SEP 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25720

| | | | | | | |
|--|--|---|---|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE LAST HARGRAVES | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-8-87 | | 2b. HOUR 6:42 PM | |
| 3. SEX F | | 4. RACE N Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4-15-13 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 8. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cook | | 11. KIND OF BUSINESS OR INDUSTRY | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP OF BALT | | 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE | | |
| 15. FATHER'S NAME FIRST French MIDDLE LAST McKoy | | 16. MOTHER'S MAIDEN NAME FIRST Matilda MIDDLE LAST Mc Nair | | 17. INFORMANT ADDRESS Mary Leach 3812 Garrison Ave. 21216 | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 18b. SOCIAL SECURITY NO 244-22-7012 | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MI 2^o coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>7/87</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cancer of the lung</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <u>9-7</u> 19 <u>87</u> , to <u>9-8</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>9-8</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE D Boersma 2067 | | DEGREE MD | | 22c. DATE SIGNED 9-8-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D BOERSMA MD | | 22e. ADDRESS Sinai Hosp of Baltimore | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-12-87 | | 23c. NAME OF CEMETERY OR CREMATORY King Mem PK. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | 24. FUNERAL DIRECTOR NAME Jas. A. Morton Sons 1101 Laurens ADDRESS | | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 10 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Gordon-Landee | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

066283 SEP 18 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25727

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN E. HARLEE | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 15, 1987 | | 2b. HOUR 7:40 P M |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 8 2 38 | | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY N/A |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN A. HARLEE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HATTIE SHELTON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 219-32-7873 | | 17. INFORMANT ADDRESS HATTIE HARLEE 963 ARGONNE DRIVE 21218 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTERSTITIAL PULMONARY FIBROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 15, 1987</u> , that (I) (we) last saw the deceased alive on <u>SEPTEMBER 15, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>John G. AHN</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. AHN | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/19/87 | 23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN, MD |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. | | ADDRESS 1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR SEP 18 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | |

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the detached papers, page 3 and 4, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10/10/87



SEP 18 1987

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose with the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST MILDRED G. MIDDLE HARMON EAST

2a. DATE OF DEATH MONTH DAY YEAR 9 22 87 2b. HOUR 12 45 PM

3. SEX

FEMALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH DAY YEAR 3 25 1905

6. AGE (IN YEARS LAST BIRTHDAY)

82

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY MD

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEATON MEDICAL CENTER

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER

12b. KIND OF BUSINESS OR INDUSTRY

SCHOOLS BALTO. PUBLIC

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

BALTIMORE

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

BALTO, MD, 3316 DORCHESTER RD, 21215

14. FATHER'S NAME

FIRST MIDDLE LAST MARCELLUS C. GOODRICH

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST KATIE DUCKETT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN) NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

214-40-6589A

17. INFORMANT

MRS. JOSIE G. SMITH

ADDRESS BALTIMORE, MD, 21215

3316 DORCHESTER RD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Atherosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years

DUE TO, OR AS A CONSEQUENCE OF

(b) Dissecting Aneurysm

years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Old Cerebrovascular Accident, Sacral Decubitus Ulcer

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-21-87 to 9-22-87, that (I) (we) last

saw the deceased alive on 9-22-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above. (I) (we) (did) (did not) sign the body after death.

22b. SIGNATURE

DEGREE

22c. DATE-SIGNED

Rolando V. Goco, MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

9/22/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Rolando V. Goco, MD

22e. ADDRESS

707 E. Fort Ave, Balt. Md 21230

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

9/26/1987

23c. NAME OF CEMETERY OR CREMATORY

ARBUTUS MEM. PARK

23d. LOCATION

CITY OR TOWN

COUNTY

BALTIMORE, MD.

STATE

24. FUNERAL HOME, ADDRESS

NUTTER FUNERAL HOMES, INC., 2501 GWYNNS FALLS PKWY, BALTO, MD. 21216

25a. DATE REC'D. BY REGISTRAR

SEP 28 1987

25b. REGISTRAR'S SIGNATURE

John Davidson-Randall

067530 SEP 30 81

COPIES FILED

SEP 30 1981

066271 SEP 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES EDMOND HAROLD | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-12-87 | | | 2b. HOUR 9:45 AM | | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 3 11 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RHODE ISLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHERIFF | | 12b. KIND OF BUSINESS OR INDUSTRY MO. STATE | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GUY LEE HAROLD | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LESLIE VIRGINIA GASKINS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT MRS. COMORA HAROLD | | BALTIMORE, MD. 21216 3123 NORMOUNT AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Metastatic Adenocarcinoma of lung. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-11-87 to 9-12-87, that (I) (we) lost saw the deceased alive on 9-12-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Sireesh Tripuraneni | | | | | | DEGREE R.D. | | 22c. DATE SIGNED 9/12/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIREESH TRIPURANENI | | | | | | 22e. ADDRESS BON SECOURS Hospital. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9/17/1987 | | 23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VET. CEM | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | | |
| 24. FUNERAL HOME (NAME AND ADDRESS) NUTTER FUNERAL HOMES, INC., 2501 GWYNNS FALLS PKWY. BALTO. MD. 21216 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then place this certificate in the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

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065885 SEP 17-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Daisy Mae Harris | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 10 87 | | 2b. HOUR 4:25 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11 17 47 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 39 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Belair MD | 7b. CITIZEN OF WHAT COUNTRY? UAS | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Cancer Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | | 13b. CITY OR TOWN Edgewood | 13c. STREET ADDRESS / ZIP CODE 2032 Rockwell St 21040 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Roy Gulbon | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Colburn | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 220-50-3452 | | 17. INFORMANT ADDRESS JAMES F. HARRIS SAME AS #13c | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 17 , 19 87 , to 9 10 , 19 87 , that (I) (we) lost saw the deceased alive on 9 10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Eun Mi Park | | DEGREE | | 22c. DATE SIGNED 9/10/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUN MI PARK | | 22e. ADDRESS U.M.C.C. 22 S. Greene Street, Baltimore, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 12 SEPTEMBER 87 | 23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD. |
| 24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Davidson | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that no death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

062882 288200 7071932 2391701

67992 OCT-887

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Debra R. Harris | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 / 25 / 87 | | | 2b. HOUR 7 ³⁵ AM | | | | |
| 3. SEX female | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 / 2 / 51 | | 6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH B-City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY D-City | | 13c. CITY OR TOWN B-City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3020 Frisbee St. 21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William A. Cox | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Velma Hickman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 214-64-7926 | | 17. INFORMANT ADDRESS Robert Harris 3020 Frisby St. 21218 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>unknown, possible pulm. embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>neurosarcoidosis s/p multiple shunts</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed</u> <u>years</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? maybe YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8 / 30</u> , 19 <u>87</u> , to <u>9 / 25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9 / 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Richmond P. Allan</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9 / 25 / 87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richmond P. Allan | | | | | | 22e. ADDRESS Sinai Hospital 21215 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9 / 30 / 87 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md. | | | |
| 24. FUNERAL DIRECTOR Chas. A. Rice FSPA 1300 Eutaw Pl. | | | | | | 25a. DATE RECEIVED BY REGISTRAR OCT 05 1987 | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE OCT 05 1987 | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and sealed by the medical examiner, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the certificate in the envelope provided and return it to the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other physical conditions, the medical examiner must be notified before burial.

206-100 38872

NOT TO BE

NOT TO BE

66903 SEP 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy NMI Harris | | | 2a. DATE OF DEATH MONTH DAY YEAR September 23, 87 | | 2b. HOUR 1700p |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 7 26 45 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of MD Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | 12b. KIND OF BUSINESS OR INDUSTRY BD OF EDUCATION | |
| 13a. STATE MD | 13b. COUNTY — | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1006 Argyle Ave 21201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Isaac Haskins | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie GHHin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-44-8912 | | 17. INFORMANT ADDRESS ANGELA W. HARRIS 1006 ARGYLE AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain death | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d. |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) possible cardiac arrhythmia | | | | | 1 week 1 week |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 14 19 87 to Sept 23 19 87 , that (I) (we) last saw the deceased alive on Sept 23 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Pamela J Amelung | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pamela J Amelung | | 22e. ADDRESS 22 S. Greene St Baltimore MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/28/87 | 23c. NAME OF CEMETERY OR CREMATORY MOUNT AUBURN CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. | | ADDRESS 1101 E. NORTH AVENUE | | 25a. DATE RECEIVED BY REGISTRAR SEP 25 1987 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

065936 SEP 17 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR
(TYPE OR PRINT)

| | | | | | | | | | |
|---|-------------------------|--|--|--|--|---|--|---|--|
| 1- FIRST WILBERT | | MIDDLE L. | | LAST HARRIS | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 4 19 87 | | 2b. HOUR 8:30 P.M. | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 01-13-24 | 6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS. | IF UNDER 1 YR. MONTHS DAYS 0 0 | IF UNDER 24 HRS. HOURS MIN. 0 0 | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 11 19 87 | | 2d. HOUR 8:30 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1701 Madison Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1701 Madison Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Harris | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Moore | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 1944-1946 | | 17. INFORMANT Wilbert Harris Jr. | | ADDRESS 2405 Alstonburg | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 9-12-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-17-87 | | 23c. NAME OF CEMETERY OR CREMATORY Crownsville Va. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Brown/Thompson F.H. | | ADDRESS P.O. Box 4433 | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Sanchez-Rodriguez</i> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25734

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIE HARRIS | | 2a. DATE OF DEATH MONTH DAY YEAR 9 23 87 | | 2b. HOUR 6:10 PM | |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 4 26 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY BALTIMORE, MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION WORKER | | 12b. INDUSTRY OR BUSINESS CONSTRUCTION CO. |
| 13a. STATE MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MELZIAH HARRIS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO. | | 16b. SOCIAL SECURITY NO. 420-14-0680A | | 17. INFORMANT MRS. HELEN L. HARRIS ADDRESS BALTIMORE, MARYLAND 3404 W. CATON AVE 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) / | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/23/87 19 87 to 9/23 19 87 that (I) (we) last saw the deceased alive on 9/23/87 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Dr. Chaper | | | | 22c. DATE SIGNED 9/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. K. CHAPER | | | | 22e. ADDRESS 3455 WILKENS AVE BALTO. MD 21229 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/29/1987 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL HOME NAME ADDRESS NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTO. MD. 21216 | | 25b. REGISTRAR'S SIGNATURE SEP 28 1987 | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR FILMS 13, 15 FILM G632 10-7-87 | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | |
|--|--|--|--|--|--|---|--|
| 1- STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| DECEASED NAME | | | | REG. NO. | | | |
| FIRST MIDDLE LAST | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| John R Harrison | | | | 09 21 87 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| M | | B 2 | | 11 14 21 | | 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| N. Carolina | | USA | | | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | University Hospital | | CONSTRUCTION | | N/A | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md | | | | Baltimore | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 17. INFORMANT | | ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| Willie Harrison | | Lillie Thompson | | KATIE McDOUGALD | | 7308 KIPLING PARKWAY 20747 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| YES | | ARMY | | 214-20-8406 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> 19 <u>87</u> to <u>9/21</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>S. McCormack</u> DEGREE <u>MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9/21</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. McCormack</u> MD | | | | 22e. ADDRESS <u>22 S. Greene St. Baltimore, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>9/23/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>GARRISON FOREST CEM</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>OWINGS MILLS MD</u> | |
| 24. FUNERAL DIRECTOR NAME <u>WM. C. MARCH F/H INC.</u> ADDRESS <u>1101 E. NORTH AVENUE</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 23 1987</u> 25b. REGISTRAR'S SIGNATURE <u>Julia Swenson-Randall</u> | | | |

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065498 SEP 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Ethel

Harthausen

2a DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b HOUR
ESTI. MATED ☐ 9/ 8/ 19 87 M

3 SEX
F

4 RACE
W

5 DATE OF BIRTH
MONTH DAY YEAR
7 4 05

6 AGE (IN YEARS)
(LAST BIRTHDAY)
82 YRS.

IF UNDER 1 YR.
MONTHS DAYS

IF UNDER 24 HRS.
HOURS MIN

2c DATE PRONOUNCED DEAD 2d HOUR
MONTH DAY YEAR 3:56 P M
9/ 8/ 19 87

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Unknown

7b CITIZEN OF WHAT COUNTRY?
U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD

10 CITY OR TOWN OF DEATH
Baltimore

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secour Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE
MD.

13b COUNTY
BALTO.

13c CITY OR TOWN
CITY

13d INSIDE CITY LIMITS?
YES ☒ NO ☐

13e STREET ADDRESS
1027 CATHEDRAL ST. 21201

14 FATHER'S NAME
FIRST MIDDLE LAST
Unknown

15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Unknown

16b SOCIAL SECURITY NO.
214-22-8334

17 INFORMANT ADDRESS
Medical Examiner

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Degenerative Arthritis

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION
STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE *Mario F. Golle, Jr.*

TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 9/9/87

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.

ADDRESS 111 Penn St., Balto., Md. 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE
9-9-87

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION CITY OR TOWN COUNTY STATE

24 FUNERAL DIRECTOR NAME

State Anatomy Board Balto., Md.

25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE

SEP 14 1987 *Julia Davidson*

DIVISION OF VITAL RECORDS, 201 W. PRINCE ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFERMENT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRINCE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

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066356 SEP 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST EDITH MIDDLE A. LAST HARTMAN

EDITH

HARTMAN

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR

9 17 87 8:30

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR 1 18 32

6. AGE (IN YEARS LAST BIRTHDAY)

55 YRS

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOST

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE) None

12b. KIND OF BUSINESS OR INDUSTRY

None

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

BALTO

13c. CITY OR TOWN

Towson

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / 7IP CODE

63 Burke Ave 21204

14. FATHER'S NAME

Isaac

MIDDLE

Leo

LAST

Hartman

15. MOTHER'S MAIDEN NAME

Jessie

MIDDLE

A.

LAST

Gill

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)

217-86-2248

17. INFORMANT

ADDRESS Glen Burnie, Md. Myrl Hartman-501 Saratoga Ave. 21061

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

D.F.C.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Breast Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

LIVER METASTASIS

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/12/87, 19 87, to 9/17/87, 19 87, that (I) (we) last saw the deceased alive on 9/12/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

9/17/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

RASSAM ATIYEH

22e. ADDRESS

1303K COLBURY RD. BALTO 21239

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

9-21-87

23c. NAME OF CEMETERY OR CREMATORY

Carrolls Methodist

23d. LOCATION CITY OR TOWN

COUNTY

Balto., Md.

24. FUNERAL DIRECTOR

NAME

1050 York Rd.

ADDRESS

Ruck Towson Funeral Home, Inc., Towson, Md. 21204

25a. DATE REC'D. BY REGISTRAR

SEP 21 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

UNITED STATES
DEPARTMENT OF COMMERCE

STATISTICAL
DIVISION

WASHINGTON, D. C.

1900

1901

1902

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1910

1911

OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS

UNITED STATES
DEPARTMENT OF COMMERCE

STATISTICAL
DIVISION

WASHINGTON, D. C.

1900

1901

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1911

065678 SEP 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCILLE A. HASKINS | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 13 87 | | 2b. HOUR M |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 8 27 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1304 N. MONTFORD AVENUE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY N/A |
| 13a. STATE MD | | | 13b. COUNTY | 13c. CITY OR TOWN BALTO. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SONNY | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-18-9986 | | 17. INFORMANT ADDRESS CARRIE M. HOLLEY 1304 N. MONTFORD AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>ISCHEMIC HEART DISEASE</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>John H. Fetting MD</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Fetting MD | | 22e. ADDRESS Johns Hopkins Oncology Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 9/16/87 | 23c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC. | | ADDRESS 1101 E. NORTH AVE | | 25. DATE REC'D BY REGISTRAR SEP 15 1987 | |
| | | 25. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OCT - 87

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25739

| | | | | | |
|---|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) LARRY WAYNE HAWKINS JR | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/29/87 | | 2b. HOUR 2132 PM |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 9 29 87 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 19 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY OF BALTIMORE MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MARYLAND | | | 13b. COUNTY WASHINGTON | 13c. CITY OR TOWN HAGERSTOWN | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LARRY WAYNE HAWKINS | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANET ROLANDA BLOYED | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Larry W. Hawkins Sr., Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE HYALINE MEMBRANE DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) PREMATURITY DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 HRS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 29 , 19 87 , to Sept. 29 , 19 87 , that (I) (we) lost saw the deceased alive on Sept 29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Generosa C. LAZAR | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/29/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Generosa C. LAZAR | | 22e. ADDRESS 900 CATIN AVE BALTO MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-1-87 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md. | | 23e. DATE REC'D. BY REGISTRAR 10-2-87 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Andrew K. Coffman Funeral Home, Inc. | | 25. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

99

7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED
OCT 10 1990

065679 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WHALEN L. HAWKINS SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 10 87 | | 2b. HOUR M |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 5 2 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1309 RAMBLEWOOD ROAD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY M. T. BERNET |
| 13a. STATE MD | | | 13b. COUNTY | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST HERBERT HAWKINS | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE CORNISH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES | | 16b. SOCIAL SECURITY NO. 216-18-4462 | | 17. INFORMANT ADDRESS JUANITA HAWKINS 1309 RAMBLEWOOD ROAD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Prostatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/25</u> 19 <u>87</u> , to <u>9/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Davis M. Hahn</u> | | DEGREE <u>MD</u> | | 22c. DATE/SIGNED <u>9/10/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Davis M. Hahn</u> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/16/87 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT'L CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC., | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | |
| | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Lola</u> MIDDLE: <u>T.</u> LAST: <u>Hawks</u> | | | 2a. DATE OF DEATH MONTH: <u>Sept.</u> DAY: <u>26</u> YEAR: <u>1987</u> | | 2b. HOUR <u>6:15 A</u> |
| 3. SEX <u>F</u> | 4. RACE <u>Black</u> | 5. DATE OF BIRTH MONTH: <u>11.</u> DAY: <u>23.</u> YEAR: <u>23</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS | IF UNDER 1 YEAR MONTHS: _____ DAYS: _____ |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>D.C.</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balto. City, Md</u> MD | |
| 10. CITY OR TOWN OF DEATH <u>Balto. Md.</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>North Charles St General</u> | | 12a. USUAL OCCUPATION (IF WORK FOR MOST OF YEAR) <u>Childress Aid</u> | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE <u>D.C.</u> | | 13b. COUNTY <u>Balto.</u> | 13c. CITY OR TOWN <u>City</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST: <u>John</u> MIDDLE: <u>Westley</u> LAST: <u>Greene</u> | | 15. MOTHER'S MAIDEN NAME FIRST: <u>Lou</u> MIDDLE: <u>q</u> LAST: <u>q</u> | | 16. SOCIAL SECURITY NO. <u>250-20-2049</u> | |
| 17. INFORMANT <u>Ferry Hawks</u> | | 18. ADDRESS <u>1608 Montpelier</u> | | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Infected Decubitus Ulceration</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>MULTIPLE CEREBRAL INFARCTS</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 13</u> , 19 <u>87</u> , to <u>Sept 26</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>September 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Angela A. Swinson, MD</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9/26/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Angela A. Swinson, MD</u> | | 22e. ADDRESS <u>Dept. of Medicine North Charles General Hospital Baltimore, MD 21218</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>Sept. 30, 87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u> | |
| 23d. LOCATION CITY OR TOWN COUNTY <u>Balto. Md</u> | | 23e. DATE REC'D. BY REGISTRAR <u>OCT 2 1987</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Odessa G. Johnson</u> | | 25. ADDRESS <u>Balto Md</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, a medical examination must be notified at once.)

BP

065900 SEP 17-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|---|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) MILDA HAYES | | | 2a DATE OF DEATH MONTH DAY YEAR 9-9-87 | | | 2b HOUR M | | | |
| 3 SEX FEMALE | | 4 RACE NEGRO | | 5 DATE OF BIRTH MONTH DAY YEAR 5-10-10 | | 6 AGE (IN YEARS LAST BIRTHDAY) 77 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD | | 7b CITIZEN OF WHAT COUNTRY? U.S.A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5949 WESTERN RUN DRIVE | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND | | | 13b COUNTY BALTIMORE | | 13c CITY OR TOWN BALTIMORE | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST OSBY HAYES | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY JOHNSON | | | 13e STREET ADDRESS / ZIP CODE 5949 WESTERN RUN DR 21209 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 323532 | | 17 INFORMANT ADDRESS Mr Jerome PARLOR 5949 Western Run Dr 21209 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Alzheimer's Dementia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: malnutrition | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Dec 8, 1986 to Sept 9, 1987 , that (I) (we) last saw the deceased alive on Sept 2, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Mohamed S Al-Jabbar | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED 7-11-87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Mohamed S Al-Jabbar | | | | | | 22e ADDRESS 861 Park Ave. Balt. Md. 21201 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b DATE 9-14-87 | | 23c NAME OF CEMETERY OR CREMATORY Mt AUBURN CEM | | 23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | | |
| 24 FUNERAL DIRECTOR NAME JOSEPH L. RUSS | | | | | | 25a DATE REC'D. BY REGISTRAR SEP 16 1987 | | 25b REGISTRAR'S SIGNATURE Julia Davidson-Rodgers | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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066122 SEP 18 1987

FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) UNA Kate HEARST | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 14 87 | | | 2b. HOUR 10:10 AM | | | |
| 3. SEX F | | 4. RACE W I | | 5. DATE OF BIRTH MONTH DAY YEAR 08 05 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? — | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT BY SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR LAST 12 MONTHS) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 3400 Marlborough Ave 21230 | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Unknown | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 409-22-6170 | | INFORMANT James Craue 21230 | | | | ADDRESS 3400 Marlborough Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Right lung carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic left lung disease DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/11/87 to 9/14/87, that (I) (we) lost the deceased alive on 9/14/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose F. Fernandez, MD | | | | 22e. ADDRESS St Agnes Hospital Baltimore, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (ECRY) | | 23b. DATE 9/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY Hartman Cem. | | 23d. LOCATION 615 COUNTY STATE Hartman Lane 21238 Md | | | |
| 24. FUNERAL DIRECTOR Charles L. Steiner | | | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

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STATE OF MARYLAND

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

65496 SEP 15 1987

FOR
STATE
REGISTRAR

| | | | | | |
|---|---|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Wible M Helen | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 5, 1987 | | 2b. HOUR 9:22 A.M. |
| 3. SEX Female | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 3 5 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unk. | 12b. KIND OF BUSINESS OR INDUSTRY Unk. | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN City | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 21205 2000 O'dell Ave Apt 803 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unk. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unk. | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-12-0102 | | 17. INFORMANT ADDRESS Patient | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 888 Cardio-respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Probable Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF (c) Pelvic Fracture APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 37 minutes | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) None | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 P.M. 8 30 1987 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Patient fell down | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) None | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8000 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/87, 1987, to Sept 5, 1987, that (I) (we) last saw the deceased alive on Sept 5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (he) (she) (it) did not view the body after death. | | | | | |
| 22b. SIGNATURE Michael J. McHugh | | DEGREE MD | | 22c. DATE SIGNED Sept 5, 1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.J. McHugh | | 22e. ADDRESS Francis Scott Key Med Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 9-9-87 | | 23c. NAME OF CEMETERY OR CREMATORY | |
| 24. FUNERAL DIRECTOR NAME State Anatomy Board | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John Davidson | |

982100 SEP 12 81



2 57 4 5

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|-----------------|---------------|---|--|---|--|--|-------------------|------------------|--|--|--|--|---------------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Joel | | | MIDDLE Blaine | | | LAST Henderson | | | 7a. DATE KNOWN OF DEATH ESTI. <input checked="" type="checkbox"/> MONTH DAY YEAR 8-21-1987 | | | 7b. HOUR M 10:00 PM | | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR June 3, 1965 | | 6 AGE (IN YEARS) (LAST BIRTHDAY) 22 RS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8-21 1987 | | | 7d. HOUR M 10:00 PM | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Havre de Grace, Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (STU) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heating & Air Conditioning | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE Md. | | | | 13b. COUNTY Cecil | | | | 13c. CITY OR TOWN Elkton | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS 1913 Blue Ball Rd., | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carver F. Henderson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Cochran Ewing | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. 1985-1986 | | | | 17. INFORMANT Nancy C. Ewing | | | | ADDRESS Elkton, Md. 1913 Blue Ball Rd., | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:25 PM 8-21-1987 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self inflicted | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1913 Blue Ball Road, Cecil County, MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles P. Kokes | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 8-22-87 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 8-25-87 | | | | 23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cherry Hill Cecil Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Sec Funeral Home, P.A. | | | | ADDRESS Elkton, Md. | | | | 25a. DATE REC'D BY REGISTRAR AUG 26 1987 | | | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. PAGES 1, 2, AND 3 ARE TO BE RETAINED BY THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUGENE ALFRED HENRY | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 6, 1987 | | 2b. HOUR 10:04am |
| 3 SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 5 19 47 | | 6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST ZARRA TALTON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTINA WOOLFORD | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-44-9919 | | 17. INFORMANT ADDRESS BRENDA HENERY 823 E. CHASE STREET | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>endocarditis</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 18 hours 1 week. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HIV (+)</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-31</u> 19 <u>87</u> , to <u>9-6</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9-6</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Frederick M. Gessner</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>9-6-87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frederick M. Gessner MD</u> | | 22e. ADDRESS <u>600 N Wolfe St Balto, Md 21205</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/11/87 | 23c. NAME OF CEMETERY OR CREMATORY MOUNT ZION CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE LANSOWNE MD |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. 1101 E. NORTH AVE. | | | 25a. DATE REC'D BY REGISTRAR SEP 10 1987 | | |
| | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Bender-Randall</u> | | |

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REG. NO.

| | | | | | | | | | |
|----------------------------------|-----------------|-------------|-----------------|------------------|--------------------|------------|--------------|-----------------|--------|
| DECEASED NAME (LAST OR PRINT) | FIRST ALFRED | MIDDLE W | LAST HENSLEY | 2a DATE OF DEATH | MONTH SEPTEMBER | DAY 23, | YEAR 1987 | 2b HOUR 8:15 | P M |
|----------------------------------|-----------------|-------------|-----------------|------------------|--------------------|------------|--------------|-----------------|--------|

| | | | | | | | |
|----------------|------------------|--|---|-----------------|------|------------------|------|
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH OCT. 24 1913 MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| | | | | MONTHS | DAYS | HOURS | MIN. |

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY

| | | | |
|--|---|--|-----------------------------------|
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired- Brewery | 12b. KIND OF BUSINESS OR INDUSTRY |
|--|---|--|-----------------------------------|

| | | | | | | | | | | |
|------------|--|--|-------------|--|-------------------|--|---|--|--------------------------------|--|
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE | |
| Md. | | | Balto. | | Balto. | | | | 8048 Bank Street 21224 | |

| | | | | | |
|---------------|--------|---------|-------------------------|--------|------|
| FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | |
| FIRST | MIDDLE | LAST | FIRST | MIDDLE | LAST |
| Robert | | Hensler | Mary | | Love |

| | | | |
|---|-------------------------|----------------------|-------------------|
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS |
| no | 217-01-4346 | Cecelia Hensler 8048 | Bank Street 21224 |

| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--------------------|---|
| PART I. DEATH WAS CAUSED BY: | | |
| IMMEDIATE CAUSE (a) | Respiratory Arrest | 5 mins |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (b) | Cardiac Arrest | 10 mins |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | Metabolic Acidosis | 5 hrs |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | |
|-----------------------|---|---|---|
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|-----------------------|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY <table border="1"> <thead> <tr> <th>HOUR</th> <th>A.M.</th> <th>MONTH</th> <th>DAY</th> <th>YEAR</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td>19</td> </tr> <tr> <td></td> <td>P.M.</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> | HOUR | A.M. | MONTH | DAY | YEAR | | | | | 19 | | P.M. | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|-------|------|-------|-----|------|--|--|--|--|----|--|------|--|--|--|--|
| HOUR | A.M. | MONTH | DAY | YEAR | | | | | | | | | | | | | |
| | | | | 19 | | | | | | | | | | | | | |
| | P.M. | | | | | | | | | | | | | | | | |

| | | |
|---|--|---|
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21a PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21i LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|--|---|

22a I certify that (I) (this hospital) attended the deceased from 9/23, 19 87, to 9/23, 19 87, that (I) (we) last saw the deceased alive on 9/23, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|--|--------------|------------------------|--|---|----------------------------|
| 27b SIGNATURE  | DEGREE MD | ATTENDING PHYSICIAN | <input type="checkbox"/> MEDICAL DIRECTOR | <input type="checkbox"/> STAFF PHYSICIAN | 27c DATE SIGNED 9/25/87 |
|--|--------------|------------------------|--|---|----------------------------|

22d. PHYSICIAN'S NAME (TYPE OR PRINT) *LISA ESOLIN* 22e ADDRESS *600 N. Wolfe St. 21205-1*
% Johns Hopkins Hosp., Baltimore, MD

| | | | | | |
|---|----------|-----------------------------------|------------------------------|----------|-------|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN | COUNTY | STATE |
| Burial | 9/29/87 | Oak Lawn Cemetery | Baltimore | Maryland | |

| | | | | | |
|-------------------------------|--|---------------------------------|--|-------------------------------|--|
| 24 FUNERAL DIRECTOR | | 25a DATE REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| NAME Connelly Funeral Home | | ADDRESS 300 Mace Ave., 21221 | | SEP 29 1987 J. [Signature] | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN, low reported by the attending physician, retained by the hospital or attending physician, to the death certificate, that the death certificate be executed within 24 hours after death. Page 4 may be used for additional information.

TO FUNERAL DIRECTOR. After this certificate has been assigned by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial final permit. The placemarker, obolopapers, Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene, 410 North Dearborn, Chicago, Illinois, for burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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(VRA 15, 4)

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065873 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

25748

REG. NO.

| | | | | | | |
|---|--|---|--|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert V Hensley | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 9, 1987 | | 2b. HOUR 7:55pm | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 21 38 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 49 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8. CITIZEN OF WHAT COUNTRY? USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen. Hosp. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) repair | | 12b. KIND OF BUSINESS OR INDUSTRY Auto body | | 13. STREET ADDRESS / ZIP CODE 3607 Annapolis Rd. 21227 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Raymond Hensley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie HILDEBRAND | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | |
| 16b. SOCIAL SECURITY NO. 219-26-1061 | | 17. INFORMANT Evelyn R. Hensley | | ADDRESS 3607 Annapolis Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Hodgkins disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | 21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 8/24, 1987 , to 9/9, 1987 , that (I) (we) last saw the deceased alive on 9/9, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Rafael E. Espinosa | | DEGREE Attending Physician | | 22c. DATE SIGNED 9/9/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafael E. Espinosa | | 22e. ADDRESS 3001 S. Hanover St. Balt MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 09/12/87 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS Ambrose Funeral Home 1328 Sulphur Spring | | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ethel | | | 2a. DATE OF DEATH MONTH 9 DAY 06 YEAR 87 | | | 2b. HOUR 11:40 P.M. | | | | |
| 1. SEX Fe | | 4. RACE Blk. | | 5. DATE OF BIRTH MONTH 1 DAY 23 YEAR 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Florida | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balt City Md MD | | | | |
| 10. CITY OR TOWN OF DEATH Balt. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mason & Lord N.H. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LADAK | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE M.D. | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2230 E. Madison St #212/3 | | |
| 14. FATHER'S NAME FIRST MAywood MIDDLE G LAST PIDden | | | 15. MOTHER'S MAIDEN NAME FIRST HASSIE MIDDLE LAST JACKSON | | | 16. SOCIAL SECURITY NO. 212-20-0401 | | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 17b. SOCIAL SECURITY NO. 212-20-0401 | | | 17. INFORMANT ADDRESS Shirley Morrison 2230 Madison St. #212/3 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Amiotropic lateral Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Bulbar Palsy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-19 19 86 to 9-6 19 87 , that (I) (we) last saw the deceased alive on 9-6 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (abd) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Linda Bennett | | | | | | DEGREE | | 22c. DATE SIGNED 9-8-87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Bennett | | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) | | | 23b. DATE 9/10/87 | | | 23c. NAME OF CEMETERY OR CREMATORY EASTVIEW Cem. | | | 23d. LOCATION CITY OR TOWN BALTO. COUNTY STATE M.D. | |
| 24. FUNERAL DIRECTOR NAME Betts Funeral Home ADDRESS 1129 N. Caroline St | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 10 1987 | | 25b. REGISTRAR'S SIGNATURE India Davidson-Rodgers | | |

002382 SEP 14 81

20% COTTON FIBER

065445 SEP 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25750

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE CURRENT) FIRST MARY MIDDLE E. LAST HESLOP | | | 2a. DATE OF DEATH MONTH DAY YEAR Sep. 9 1987 | | | 2b. HOUR 1:42 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6 01 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Oper. | | 12b. KIND OF BUSINESS OR INDUSTRY Tool factory Balto. | |
| 13a. STATE MD | | 13b. COUNTY ----- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST George MIDDLE M. LAST Wolf | | 15. MOTHER'S MAIDEN NAME FIRST Lillie LAST - Hilton | | 13e. STREET ADDRESS / ZIP CODE 131 E GITTINGS ST. MD 21230 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 220-075789 | | 17. INFORMANT John J. Heslop, Same as above | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). LUNG Cancer | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years |
| DUE TO, OR AS A CONSEQUENCE OF (b). Breast Cancer | | years |
| DUE TO, OR AS A CONSEQUENCE OF (c). Chronic Obstructive pulmonary Disease | | years |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19 | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Shu-UN Yang | | | | DEGREE MD | | 22c. DATE SIGNED 9/9/1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHU-UN YANG MD | | | | 22e. ADDRESS Mercy Hospital Baltimore City | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/11/87 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co. Md. | |
| 24. FUNERAL DIRECTOR NAME Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Harrison | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Even if the funeral home removes carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

08242 SEP 12 85

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

066328 SEP 22-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 5 7 5 1

REG NO

| | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) Dorothy Dalton Hettche | | | 2a DATE OF DEATH MONTH DAY YEAR 9 19 87 | | | 2b HOUR 10:07 PM | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 8 22 18 | | 6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical | | 12b KIND OF BUSINESS OR INDUSTRY Office Work | |
| 13a STATE Maryland | | 13b COUNTY Queen Anne's | | 13c CITY OR TOWN Queenstown | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Homer Curtin | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Colein | | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES GIVE WAR OR DATES) NO | | | |
| 16b SOCIAL SECURITY NO 216-09-8306 | | 17 INFORMANT ADDRESS LeRoy Hettche Rt. 1 Box 161 21658 | | | | 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>30 min.</u> <u>2 wks</u> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Pancreatic phlegmon</u> | | | | | | | | | |
| 19a DATE OF OPERATION 9/14/87 | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Sepsis for probable abdominal source</u> | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from <u>9/13</u> 19 <u>87</u> to <u>9/19</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>9/19</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | |
| 22b SIGNATURE <u>Clifford Tribus</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED 9/19/87 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Clifford Tribus, M.D. | | | | 22e ADDRESS Union Memorial Hospital | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 9/22/87 | | 23c NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | | 23d LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland | | | |
| 24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 24a DATE REC'D. BY REGISTRAR 21229 | | 24b REGISTRAR'S SIGNATURE SEP 21 1987 <u>Julia Davidson-Randall</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please attach certificate to pages 1 and 2 and should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. Permitting burial without this certificate is a violation of the law. IMPORTANT: If item 21 is marked, see 18 shows any injury or other condition which may be the cause of death.

BP

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REGIA VOLTOS & CO

INVERNATI

SEP 21 1981

065139 SEP 10 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25752

| | | | | | | | | | |
|--|--|---|---|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTHER HETTMAN | | | 2a DATE OF DEATH MONTH DAY YEAR SEPT. 15, 1987 | | | 2b HOUR 9:45 AM | | | |
| 3 SEX FEMALE | | 4 RACE CAUCASIAN | | 5 BIRTH MONTH DAY YEAR AUGUST 31, 1884 | | 6 AGE (IN YEARS LAST BIRTHDAY) 103 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINSON HEBREW GERIATRIC CENTER HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILLINERY | | 12b KIND OF BUSINESS OR INDUSTRY HATS | |
| 13a STATE MARYLAND | | | 13b COUNTY BALTIMORE | | 13c CITY OR TOWN BALTIMORE | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST LEON BONDROFF | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GOLDIE UNKNOWN | | | 13e STREET ADDRESS / ZIP CODE 2506 WETHERBURN RD. 21209 | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b SOCIAL SECURITY NO. 216-01-2876 | | 17 INFORMANT ADDRESS MRS. HARRY GOLDMAN 2506 WETHERBURN RD. 21209 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from 9/1 to 9/1 19 87 that (we) last saw the deceased alive on 9/1 19 87 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Esther | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/1/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRENTA O. KIM | | | 22e. ADDRESS LEVINSON HEBREW GERIATRIC CENTER HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 9/3/87 | | 23c. NAME OF CEMETERY OR CREMATORY FORBAND CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO MD | | |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO, MD 21215 | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 9 1987 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE John Davidson-Pond | | | | | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

002130 SEP 10 61

SEP 08 1961

067219 SEP 30 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1- REGISTRAR | | 2a DATE KNOWN OF DEATH | | 3 MONTH DAY YEAR | | 4b HOUR | |
| 5 NAME (TYPE OR PRINT) | | 6 FIRST | | 7 MIDDLE | | 8 LAST | |
| Erica | | L. | | Hikes | | | |
| 9 SEX | | 10 RACE | | 11 DATE OF BIRTH | | 12 AGE (IN YEARS) | |
| Female | | White | | 04-29-1971 | | 16 YRS. | |
| 13a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 13b CITIZEN OF WHAT COUNTRY? | | 14 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 15 BALTIMORE CITY OR COUNTY OF DEATH | |
| Annapolis, Md. | | United States | | | | Baltimore City | |
| 16 CITY OR TOWN OF DEATH | | 17 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 18 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 19 KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | University Hospital | | Student | | High School | |
| 20 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 21a STATE | | 21b COUNTY | | 21c CITY OR TOWN | |
| Md. | | A.A. | | Severna Park | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 22a FATHER'S NAME | | 22b MOTHER'S MAIDEN NAME | | 23a STREET ADDRESS | | 23b INSIDE CITY LIMITS? | |
| Carl L. Hikes | | Kathryn A. Fedak | | 411 Fernwood Dr. / 21146 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 24 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 24b SOCIAL SECURITY NO. | | 25 INFORMANT | | 25b ADDRESS | |
| No | | 216-88-7150 | | Mr. Carl Hikes | | 411 Fernwood Dr. Severna Park, Md. 21146 | |
| 26 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Head injuries</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) _____ | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) _____ | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 27a DATE OF OPERATION | | | | | | | |
| 27b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | |
| 28 AUTOPSY? | | | | | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 29a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | |
| 29b TIME OF INJURY | | | | | | | |
| 29c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 29d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | | | | |
| 29e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | |
| 29f LOCATION | | | | | | | |
| 29g CITY OR TOWN | | | | | | | |
| 29h COUNTY | | | | | | | |
| 29i STATE | | | | | | | |
| 29j I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| 29k TITLE (SPECIFY) | | | | | | | |
| 29l DATE SIGNED | | | | | | | |
| 29m EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | |
| 29n ADDRESS | | | | | | | |
| 29o BURIAL, CREMATION REMOVAL (SPECIFY) | | | | | | | |
| 29p DATE | | | | | | | |
| 29q NAME OF CEMETERY OR CREMATORY | | | | | | | |
| 29r LOCATION | | | | | | | |
| 29s COUNTY | | | | | | | |
| 29t STATE | | | | | | | |
| 30 FUNERAL DIRECTOR | | | | | | | |
| 30a NAME | | | | | | | |
| 30b ADDRESS | | | | | | | |
| 30c DATE REC'D BY REGISTRAR | | | | | | | |
| 30d REGISTRAR'S SIGNATURE | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

ROBERT S. BARRANCO
SEVERNA PARK, MD. 21146

J.A.B.

SEP 24 1987

Julia Swinson-Rudabaugh

027519 SEP 30 87

SEVERNA PARK, MD 21146
ROBERT S BARRANCO

100% COTTON 1987



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 5 7 5

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

[illegible]

| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | ESTI- MATED | MONTH | DAY | YEAR | 2b. HOUR |
|---|---------|---|--------|---|--|--|--------------------------------------|---|--------------------------|--|------------|
| JAMES | | | | T. HILL | 9-29 | | X | 9 | 29 | 19 87 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| MALE | BLACK | 3 31 13 | | 74 YRS. | MONTHS DAYS | | HOURS MIN. | | 10-2- 19 87 | | 12:00 P.M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MD | | USA | | | | | Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 201 N. Washington Street | | | | SMITH TRANSFER | | RETIRED | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | 2123 APT. 900 | |
| MD | | | | BALTIMORE | | | | 201 N. WASHINGTON STREET | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| SAMUEL | | | | DAISY | | | | GREEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 218-01-0751 | | IRA HILL | | 5482 B. LANGLEY WAY/ DC | | BOLLING A.F.B. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | M.D. | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | | |
| charles P. Kokes, M.D. | | | | Assistant | | | | 10-2-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | |
| BURIAL | | 10/8/87 | | CEDAR HILL CEMETERY | | ANNE AUNDEL CO. | | MD | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| NAME ADDRESS | | OCT 8 1987 | | Kelia Henderson-Pandey | | | | | | | |
| WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | | | | | | | | |

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(VR A15 ME (5))

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MADE IN U.S.A.



MADE IN U.S.A.

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FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | ESTIMATED | | | 3b. HOUR | | |
| JOHN | | | R. | | | HILL | | | 9 1 19 87 | | | 9:09 A.M. | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | | 7. IF UNDER 1 YR. | | |
| M | | | B 2 | | | 11 20 10 | | | 76 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | NEVER MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| VA | | | U.S.A. | | | WIDOWED | | | DIVORCED | | | Baltimore City | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | 1300 E. Lanvale St. | | | RETIRED | | | N/A | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| MD | | | | | | BALTO. | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1300 E. LANVALE STREET 21213 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | NO | | | 215-07-4649 | | | MATTIE SURER 1100 BOLTON STREET APT 403 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| IMMEDIATE CAUSE (a) | | | Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | Chronic obstructive pulmonary disease | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TO PART 1 OR PART 2) | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | CITY OR TOWN | | | COUNTY STATE | | |
| | | | | | | STREET | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | | | | |
| | | | Deputy Chief | | | 9-1-87 | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | 111 Penn St. Balto., MD | | | 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | COUNTY STATE | | |
| BURIAL | | | 9/4/87 | | | BALTIMORE CEMETERY | | | BALTIMORE | | | MD | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| WM. C. MARCH F/H INC., 1101 E. NORTH AVENUE | | | SEP 3 1987 | | | T. Anderson-Randall | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRISTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXAMINED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PARAGRAPH ITEM 18. GIVE PARAGRAPH 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRISTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|---|--|------------------------------------|--|--|----------------|---|--|--------------------------------------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | | |
| MARTHA | | | HILL | | | 9 | | | 7 | | | 19 87 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| FEMALE | | BLACK | | 8 18 10 | | 77 YRS. | | MONTHS DAYS | | HOURS MIN. | | 9 7 19 87 | | 4:33 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| VA | | | | USA | | | | | | | | Baltimore City MD | | | |
| 11. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | 1036 N. Valley St. | | | | HOME MAKER | | | | N/A | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MD | | | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1036 N. VALLEY STREET 21202 | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| POMPY | | | | GARY | | | | MATTIE | | | | BOOKER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| NO | | | | 218-22-4977 | | | | FLORENCE HILL 1036 N. VALLEY STREET | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a. | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| | | | | M.D. Deputy Chief | | | | MEDICAL EXAMINER | | | | 9-8-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | | | 9/12/87 | | BALTIMORE CEMETERY | | | | BALTIMORE MD | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| WM. C. MARCH F/H INC. | | | | 1101 E. NORTH AVE. | | | | SEP 10 1987 | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

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WINTER

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67101 SEP 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 25751

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) DAVID THOMAS HILLIARD SR. DAVID Hilliard | | 2a. DATE OF DEATH (MONTH DAY YEAR) September 26, 1987 9-26-87 | | 2b. HOUR 6:40 P.M. | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH (MONTH DAY YEAR) March 31, 1916 | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY Med. Cent | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed | 12b. KIND OF BUSINESS OR INDUSTRY Home Improvment | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4921 Goodnow Rd. Apt. E 21206 |
| 14. FATHER'S NAME FIRST Isham MIDDLE LAST Hilliard | | 15. MOTHER'S MAIDEN NAME FIRST Parlie MIDDLE LAST Ward | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 237-10-0946 | | 17. INFORMANT Geneva L. Hilliard ADDRESS 7046 Rudsell Ct. 21207 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dilated Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-26 , 19 87 , to 9-26 , 19 87 , that (I) (we) last saw the deceased alive on 9-26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Grace A. Cordts MD | | DEGREE MD | | 22c. DATE SIGNED 9-26-87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GRACE A. CORDTS MD | | 22e. ADDRESS FSK MC Baltimore Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-30-87 | 23c. NAME OF CEMETERY OR CREMATORY Community Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Tarboro, Edgecomb Co. No. Car. |
| 24. FUNERAL DIRECTOR Marshall W. Jones, Jr. F.H. 4T01 | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Swindon Rodale | |

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20% COTTON BIBLES

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 5 7 5 8

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JANET Ann HILTE | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 14, 1987 | | | 2b. HOUR 1:48 PM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 21, 1941 | | 6. AGE (IN YEARS LAST BIRTHDAY) 46 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Easton, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Variety Store | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY - 13c. CITY OR TOWN Baltimore | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leslie Willis Beall | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Whitely | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No - | | 16b. SOCIAL SECURITY NO. 216 38 7346 | | 17. INFORMANT ADDRESS Bernard T. Hilte, Husband Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) RIGHT VENTRICULAR INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 13, 1987, to SEP. 14, 1987, that (I) (we) last saw the deceased alive on SEP. 14, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE MD | | | | 22c. DATE SIGNED 9/14/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan D. Kushner | | | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/17/87 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md. | | | |
| 24. FUNERAL DIRECTOR <i>[Signature]</i> Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. 21221 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

1025877 SEP 18 87

067191

SEP 30 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|---|---|--|--|---|---|-----------------|
| 1. DECEASED NAME (PRINT) FIRST MIDDLE LAST MARIE HILTZ | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/25/87 | | | 2b. HOUR 1205 P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 5 17 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 74 HRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Housework | |
| 13a. STATE Md. | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Frederick Tribull | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Jankiewicz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-12-5406 | | 17. INFORMANT ADDRESS Joseph H. Hiltz 119 Rochester Pl. 21224 | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE CARDIOMYOPATHY | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: CHRONIC RENAL FAILURE, ANEMIA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT. 22 , 19 87 , to SEPT. 25 , 19 87 , that (I) (we) lost saw the deceased alive on SEPT. 25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Kenneth D. Byerly | | | | DEGREE MD | | 22c. DATE SIGNED 9/25/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH D. BYERLY | | | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-28-87 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. | | | | ADDRESS 401 S. Conkling St | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Julia D. Baker-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTER

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND P. HINTENACH | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20 1987 | | 2b. HOUR 9A M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 12 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4110 HARRIS AVE. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REFRIG. TECH. | | 12b. KIND OF BUSINESS OR INDUSTRY MEAT CO. |
| 13a. STATE MD. | 13b. COUNTY - | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4110 HARRIS AVE. 21206 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH HINTENACH | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET DILLMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-10-5003A | | 17. INFORMANT ADDRESS JANICE PETR 5414 GERLAND AVE. 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE DURATION BETWEEN ONSET AND DEATH <i>7+yr</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/12/80</i> 19 <i>80</i> to <i>9/20</i> 19 <i>87</i> that (I) (we) lost spw. the deceased alive on <i>8/24</i> 19 <i>87</i> and (not in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Dr. William Renner</i> | | DEGREE | | 22c. DATE SIGNED <i>9/21/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM RENNER | | 22e. ADDRESS 3222 ST. PAUL ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 9/23/87 | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | |
| 24. FUNERAL HOME SCHIMONEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Randner</i> | |

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065864 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

25761
25761
25761

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Michael L. Hnat | | | 2a. DATE OF DEATH MONTH DAY YEAR September 6, 1987 | | 2b. HOUR M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR August 14, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shearman | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1708 Watervale Road 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael L. Hnat | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Bukovecsky | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 213-07-2593 | | 17. INFORMANT ADDRESS Loretta M. Hnat 1708 Watervale Ave. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Obesity</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Robert L. Marcus, MD</u> | | | | 22c. DATE SIGNED 9/8/87 | |
| 22e. ADDRESS 1576 Merritt Blvd, Balt, MD 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-10-87 | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222 | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | |
| | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

022804 SEP 12 81



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. The placard for the coroner's office should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, disease, or traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) A. BERTHOLD HOEN | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 10, 1987 | | 2b. HOUR 6 A. M. |
| 3 SEX Male | 4. RACE White | 5. DATE OF BIRTH October 13, 1897 | 6. AGE (IN YEARS LAST BIRTHDAY) 89 | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 100 Ridgewood Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Board Chairman | 12b. KIND OF BUSINESS OR INDUSTRY Hoen Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 100 Ridgewood Rd. 21210 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert B. Hoen | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lyons | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I | 17. INFORMANT ADDRESS Mary W. Hoen Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 22, 1965</u> to <u>Sept 10, 1987</u> , that (I) <u>last</u> saw the deceased alive on <u>Sept 9, 1987</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>W B Daniels, Jr.</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9/11/87</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Worth B. Daniels, Jr. M.D. | | 22e. ADDRESS 11 E. Chase St. Baltimore, Md. 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/12/87 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | 25. FILED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 14 1987 <u>Julia Davidson-Randall</u> | | | |

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067662 OCT

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
RECORDER
-6-87

| | | | | | | | | | | | | | | | | | |
|---|---------|---|--|---|--|--|--|--------------------------------------|--|--------------------------|--|-------|--|---|--|-----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| VINCENT | | | | | | HOFMAN | | X 9 | | 27 | | 19 | | 87 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| M | W | 7 20 04 | | 83 YRS | | MONTHS | | DAYS | | 9 27 | | 19 | | 87 | | 1:47 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| MD. | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 2000 O'Dell Ave. | | SALESMAN | | SALES | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD. | | | | BALTIMORE | | YES X NO | | 2000 O'DELL AVE. APT. 212 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| UNK. | | UNK. | | (YES, NO, OR UNKNOWN) | | 213-09-4539 | | DAVID DUNKLE-3711 ERDMAN AVE. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| <u>Maryanne Brecknell</u> | | Deputy Chief | | 9-30-87 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Penn St., Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN) | | COUNTY | | STATE | | | | | | | |
| Removal | | 9-27-87 | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25. NAME AND ADDRESS OF PERSON RECEIVING REMAINS | | | | | | | | | | | |
| State Anatomy Board | | Balto., Md. | | 067051987, J. J. [Signature] | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (1))

001-005 001-201

100% COTTON FIBER

WASH

WASH



Wash 20730

064865 SEP-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) MARIE E HOGG | | 2a. DATE OF DEATH MONTH DAY YEAR 9-3-1987 | | 2b. HOUR 10:30 AM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 5 14 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Balto | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. STREET ADDRESS Balto., Md. 719 Stamford Rd. #21229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ? Nappel | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Hein | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 213-05-2990 | | 17. INFORMANT Mr. Joseph S. Hogg, Jr. ADDRESS 917 Turnbull Rd. Randallstown, Md. #21133 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe hypertensive congestive Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) Renal insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/26/87 to 9/3/87 that (I) (we) last saw the deceased alive on 9/3/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE JOSE F. FERNANDEZ, MD | | DEGREE MD | | 22c. DATE SIGNED 9-3-1987 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS St. Agnes Hospital Baltimore, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 5, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. Balto. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | 23e. NAME OF CEMETERY OR CREMATORY St. Agnes Hospital Baltimore, Md | | 23f. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24. FUNERAL DIRECTOR G. Truman Schwab | | 5151 Balto. Nat'l. Pike #21229 | | 25a. DATE REC'D. BY REGISTRAR SEP 4 - 1987 | |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body. IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a possible homicide.

[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

066261 SEP 18 1987

Items 18 thru 22a Film G632 9/29/87
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25765

REG. NO.

| | | | | | | | | | |
|--|--|-------------------------|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MICHAEL D. HOLLIS | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 12 1987 | | | | 7b. HOUR M | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 9 27 53 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 33 | | IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FULLTIME | | | | 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | | | 13. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 12 1987 | |
| 13a. STATE MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM R. THOMAS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHIRLEY HOLLIS | | | | 16. SOCIAL SECURITY NO. 212-66-0397 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | 16b. (IF YES, GIVE WAR OR DATES) ARMY | | 17. INFORMANT ADDRESS DEBORAH HOLLIS 2238 E. NORTH AVENUE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotic and Ethanol Intoxication (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR not known 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject used drugs | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2226 E. North Avenue Baltimore City, MD | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 9-13-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 9/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | |
| 24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H INC. | | | | ADDRESS 1101 E. NORTH AVENUE | | 25a. DATE REC'D. BY REGISTRAR SEP 17 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP 773
 DHMH - 17
 (VR A15 ME (5))

069501 SEP 10 83

REBIL MOTION & CO

WINTER

2000

25

065003 SEP 9 1987

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|---|--|---|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLYDE L. HOLLOWAY | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1, 1987 | | 2b. HOUR 10:40A M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1919 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman | | | 12b. KIND OF BUSINESS OR INDUSTRY County Highway Dept. | | | |
| 13a. STATE Freeland, Md. | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Freeland | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas L. Holloway | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Ellen Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II | | 17. INFORMANT ADDRESS 1726 Brooks Road, Agertha B. Holloway Freeland, Md. 21053 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METABOLIC INSTABILITY, renal Tk, 9/1/87</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS, Hemodynamic instability</u> Approximate interval between onset and death: 24 HRS 4-5 days 2 wks | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>UNRESECTABLE KLASCHIN TUMOR</u> | | | | | | |
| 19a. DATE OF OPERATION 8/13/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED KLASCHIN TUMOR | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. certify that (I) (this hospital) attended the deceased from <u>8/14</u> <u>87</u> to <u>9/1</u> <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/1</u> <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <u>Bradley C. Rosen</u> | | DEGREE MD | | 22c. DATE SIGNED 9/1/87 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bradley C. Rosen | | 22e. ADDRESS 600 N. WAVE ST. JONES HOPKINS BALTIMORE, MD 21205 | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 4, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion United Meth. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Freeland, Baltimore Co., Md. | | 24. FUNERAL DIRECTOR NAME J. J. Hartenstein | | 25a. DATE REC'D BY REGISTRAR SEP 8 1987 | | |
| 25b. REGISTRAR'S SIGNATURE 100 R. J. ... | | 25c. REGISTRAR'S SIGNATURE | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1, 2, and 3, and send them with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

68049 OCT-88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25767
1
2a. DATE KNOWN OF DEATH ESTIMATED ☒ MONTH DAY YEAR 9/ 30/ 19 87 2b. HOUR M 11:47 a.m.

FOR
1- STATE
REGISTRAR

| | | | | | | |
|--|--------------|--|---|---|---|--|
| DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9/ 30/ 19 87 2b. HOUR M 11:47 a.m. | |
| Louis | | K. | | Holt | | |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR 5 29 1969 | 6 AGE (IN YEARS) (LAST BIRTHDAY) 18 YRS | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9/ 30/ 19 87 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Medical Center | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student 12b. KIND OF BUSINESS OR INDUSTRY High School | |
| 12c. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Massachusetts 13b. COUNTY Worcester 13c. CITY OR TOWN Milford | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 11 Hemlock Lane | | |
| 14 FATHER'S NAME FIRST Raymond MIDDLE H. LAST Holt | | 15 MOTHER'S MAIDEN NAME FIRST Roseann MIDDLE Porrazzo LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 033-50-7788 17 INFORMANT Raymond H. Holt ADDRESS 11 Hemlock Lane Milford, Massachusetts | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Multiple Injuries

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

| | | | |
|--|---|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:55xx 9/ 30/ 19 87 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto/tractor trailer collision | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 195 at 695, Baltimore County, Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10/1/87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | |

| | | | |
|--|-------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 10-5-87 | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Milford, Worcester, Massachusetts |
| 24 FUNERAL DIRECTOR NAME Marzullo Funeral Service ADDRESS Upperco, MD. | | 25a. DATE REC'D BY REGISTRAR OCT 06 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DPH/17
(VR A15 ME (5))

288-100 04082

GREEN MOTION PICTURE



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|---|---|--|
| 1. DECEASED NAME (PRINT) FIRST MIDDLE LAST EDITH C. HOOD | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 / 23 / 87 | | 2b. HOUR 6:37 AM |
| 3. SEX Female | 4. RACE White Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 8 / 11 / 24 | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS MONTHS DAYS HOURS MIN. | | IF UNDER 1 YEAR IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 4201 PENNINGTON AVE, 21226 |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HANNON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HEORICK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NUMBER 219-189-037 | | 17. INFORMANT ADDRESS Barney L. Lyon 3001 S. Maple Road Linthicum, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>OVARIAN CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I (this hospital)) attended the deceased from 9/17/1987 to 9/23/1987 that I (we) last saw the deceased alive on 9/23/1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Nick F. Musso, MD | | DEGREE MD | | 22c. DATE SIGNED 9/23/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nick F. Musso, MD | | 22e. ADDRESS 3001 S. Hanover St., Baltimore, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 25, 1987 | 23c. NAME OF CEMETERY OR CREMATORY Gettysburg Nat. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Gettysburg Penna. |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Twiston-Randall | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) JOSEPH C. HOOD, SR | | | 2a DATE OF DEATH MONTH DAY YEAR 9-26-87 | | 2b HOUR 12:19 PM |
| 3 SEX M | 4 RACE B | 5 DATE OF BIRTH MONTH DAY YEAR 4-16-11 | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD | | |
| 10 CITY OR TOWN OF DEATH Baltimore | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md 13b COUNTY Baltimore 13c CITY OR TOWN Baltimore | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 204 N. Monroe St 21223 |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 240-12-5675 | 17 INFORMANT ADDRESS Betty H. Jones 204 N. Monroe St | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis - vent. fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) ASCD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I To | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 9/26 19 87 to 9/26 19 87 that (I) (we) lost saw the deceased alive on 9/26 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE J. BELTRAN | | DEGREE MD | | 22c DATE SIGNED 9/26/87 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) J. BELTRAN | | 22e ADDRESS 1940 W. BALTIMORE ST, BALTO | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 10/1/87 | 23c NAME OF CEMETERY OR CREMATORY Md National Mem Park | | 23d LOCATION CITY OR TOWN COUNTY STATE Laurel Md 21223 |
| 24 FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue ADDRESS | | | 25a DATE REC'D BY REGISTRAR SEP 29 1987 25b REGISTRAR'S SIGNATURE Julia Sanders-Randall | | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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066204 SEP 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

E0321605

REG. NO.

| | | | | | | | |
|---|--|--|---|---|---------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Garnet B Hook | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 14 87 | | 2b. HOUR 8:38 P_M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 04 11 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Gen. Contractor | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD | | 13c. COUNTY Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4536 Mon View Pl. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ? ? ? | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Truitt Dalton | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 25-24-0016A | |
| 16c. ADDRESS Charles E. Bradley 4536 Mon View Pl. | | 17. INFORMANT Charles E. Bradley | | 17. ADDRESS 4536 Mon View Pl. | | 17. CITY OR TOWN Baltimore | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small cell cancer of lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-16-87 , 19____, to 9-14-87 , 19____, that (I) (we) saw the deceased alive on 9-14-87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Paul E. Gormley | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul E. Gormley | | 22e. ADDRESS 900 Caton Ave Balt. Md. 2110 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Buried | | 23b. DATE 9-18-1987 | | 23c. NAME OF CEMETERY OR CREMATORY St. Anne's | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME John J. Brown & Son Inc. 901 Hollins St. | | 25. DATE REC'D. BY REGISTRAR SEP 18 1987 | | 26. REGISTRAR'S SIGNATURE Julia Sanders-Randall | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 5 1 7 1

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|---|---|--|--|---|------------------|--|------------------|----------------------|
| 1- DECEASED NAME (PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Alice | | E. | Hoover | | 09 | 03 | 87 | 25 | 4 ³⁷ A.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | White | MONTH DAY YEAR 02 09 25 | | 62 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | | Balto. City | | MD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Balto. | Deaton Hosp & Med Center-South | | Cafeteria Manager | | School | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. STATE | 13c. COUNTY | 13d. CITY OR TOWN | 13e. INSIDE CITY LIMITS? | 13f. STREET ADDRESS, ZIP CODE | | | | |
| | MD. | A.A. | Balto. | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 5233 4th Street, 21225 | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST Marshall | | FIRST MIDDLE LAST Florence Poe | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | |
| No | | 219/12 1941 | | Louis W. Hoover | | Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal lung carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/2</u> 19 <u>87</u> to <u>9/3</u> 19 <u>87</u> that (I) (we) lost <u>saw the deceased alive on above, (I) (we) did not view the body after death.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| <u>DR VAZQUEZ</u> | | | | | | 9/3/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| DR VAZQUEZ | | Sath Baltimore General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) | | | | |
| Burial | | 9/5/87 | Glen Haven Mem Park | | Glen Burnie A.A. Md | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| George J. Gonce 4001 Ritchie Hwy Balto Md | | | | | SEP 04 1987 | | John Davidson-Randall | | |

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 25112

| | | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ISA M. Hopkins | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-27-87 | | | 2b. HOUR 3:25 AM | | | | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 10 24 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HAVEN NSg Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner | | | 12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning | | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3939 Penhurst Avenue, 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Myron Corwin | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Asseltine | | | 17. INFORMANT ADDRESS Carolyn Smiley, 1703 Georgia Avenue | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 367-07-3786 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-22-86</u> to <u>9-27-87</u> , that (I) (we) lost saw the deceased alive on <u>9-22-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9-28-87 | | | |
| 22d. PHYSICIAN'S NAME Dr. Ordonezsmith | | | 22e. ADDRESS 303 N. Rolling Road | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/1/87 | | 23c. NAME OF CEMETERY OR CREMATORY Roseland Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Jackson Jackson Michigan | | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | | ADDRESS 21229 4107 Wilkens Ave. | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1987 | | | 25b. REGISTRAR'S SIGNATURE | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

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SEP 29 1983

1 - FOR
007 STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--------------|---|--|--|--|--|--|----------------------------|--|
| 1 DECEASED NAME (TYPE OR PRINT) NORINE | | | | | | FIRST MIDDLE LAST Dorothy HOPPA | | | | | | | | | | | | | | | |
| | | | | | | 2a DATE OF BIRTH MONTH YEAR DAY 1987 | | | | | | | 2b HOUR MIN. | | | | | | | | |
| 3 SEX Female | | | | | | 4 RACE White | | | | 5 DATE OF BIRTH MONTH DAY YEAR 1921 | | | | 6 AGE IN YEARS LAST BIRTHDAY YRS 66 | | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland | | | | | | 7b CITIZENSHIP OF WHAT COUNTRY? U.S.A. | | | | 8 MARRIED NEVER MARRIED WIDOWED DIVORCED X | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | | | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Church Hospital | | | | | | | | 12a USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE Housework | | | | 12b KIND OF BUSINESS OR INDUSTRY At Home | | | |
| 13a USUAL RESIDENCE IF NOT AT HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION Md. | | | | | | 13b COUNTY ----- | | | | 13c CITY OR TOWN Baltimore | | | | 13d INSIDE CITY LIMITS? YES NO X | | | | 13e STREET ADDRESS / ZIP CODE 6813 Bank Street 21224 | | | |
| 14 FATHER'S NAME FIRST Middle Last Joseph C O'Connor | | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Mary Rykowski | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED SERVICES? No | | | | | | 16b SOCIAL SECURITY NO. 218-10-2500 | | | | 17 INFORMANT ADDRESS Leonard J. Hoppla 6813 Bank Street 21224 | | | | | | | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST | | | | | | | | | | | | | | | | | | | | | |
| DUPLICATE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUPLICATE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | | | | | | | | | | | |
| PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a) | | | | | | | | | | | | | | | | | | | | | |
| X X X X X X X X X X X X X X RENAL FAILURE | | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a AUTOPSY? YES NO X | | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO | | | | | |
| 21a ACCIDENT WAS UNDERLYNG OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 21b TIME OF INJURY HOUR AM P.M. MONTH DAY YEAR 19 | | | | | | 21c HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2 | | | | | | | | | |
| 21d INJURY OCCURRED WHITE NOT WHITE AT WORK AT WORK | | | | | | 21e PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC | | | | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from AUGUST 5 1987, to SEPTEMBER 7 1987, that (I) (we) last saw the deceased alive on SEPTEMBER 7 1987, and that in my opinion death occurred on the date and hour and from the causes stated above; (I) (we) did view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE Dr. A. Nazemi M.D. DEGREE | | | | | | | | | | | | | | ATTENDING PHYSICIAN MEDICAL STAFF DIRECTOR PHYSICIAN X | | | | 22c DATE SIGNED 9/7/87 | | | |
| 22d PHYSICIAN'S NAME TYPE OR PRINT ATAOLLAH NAZEMI | | | | | | | | | | | | | | 22e ADDRESS CHURCH HOSPITAL CORPORATION 100 n. BROADWAY BALTIMORE, MD. 2123 | | | | | | | |
| 23a BURIAL CREMATATION REMOVAL SPECIFY Burial | | | | | | 23b DATE 9-10-87 | | | | 23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | | | 23d LOCATION CITY OR TOWN EASTWOOD Balto Co., Md. COUNTY STATE | | | | | | | |
| 24 FUNERAL DIRECTOR Charles S. Zeiler & Son Inc. ADDRESS 6224 Eastern Ave. | | | | | | | | | | | | | | 25a DATE REC'D BY REGISTRAR SEP 8 - 1987 | | | | 25b REGISTRAR'S SIGNATURE Julia Davidson-Rudner | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG-100

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HARRY Harry Edward | | 2. DATE OF DEATH MONTH DAY YEAR 9 11 87 | | 2b HOUR 10 ²⁰ P.M. | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR August 7 1927 | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 9. CITIZEN OF WHAT COUNTRY? USA | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 12. CITY OR TOWN OF DEATH Baltimore | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MASON F LOBO, Francis Scott Key | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 15. KIND OF BUSINESS OR INDUSTRY Maintenance |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a STATE MD | | 17. COUNTY Baltimore | 18. CITY OR TOWN Middle River | 19. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20. STREET ADDRESS / ZIP CODE 18 Village Green 21220 |
| 21. FATHER'S NAME FIRST MIDDLE LAST Harry E. Horning | | 22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys E. Allender | | | |
| 23a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes | 23b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean | 24. 220 22 5307 | 25. INFORMANT Edith M. Earling Sister | | 26. Same |
| 27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>HOOGLINS DISINFECTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 d. 4 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | |
| 28a DATE OF OPERATION | | 28b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 29a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 29b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 30a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 30b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 30c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 31a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 31b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 31c LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 32a I certify that (1) (this hospital) attended the deceased from <u>9/11/87</u> 19 <u>87</u> to <u>9/11/87</u> 19 <u>87</u> , that (1) (we) last saw the deceased above, (1) (we) (did) (did not) see the body after death. | | | | | |
| 32b SIGNATURE <u>Richard E. Pruddzinski</u> | | DEGREE MD | | 32c DATE SIGNED 9/12/87 | |
| 32d PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Pruddzinski | | 32e ADDRESS 4440 Eastern Avenue Baltimore MD 21224 | | | |
| 33a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 33b DATE 9/14/87 | 33c NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Garden | | 33d LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md. | |
| 34 FUNERAL DIRECTOR Pruddzinski Funeral Home | | 34b ADDRESS PA 1407 Old Eastern Ave. | | 35a DATE REC'D BY REGISTRAR SEP 14 1987 | 35b REGISTRAR'S SIGNATURE Julia Dendron-Randall |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 1 should be detached for use as the burial/transport permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

082625 229 12 61

066522 SEP 23 1987

Unknown #87-96

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|---------|------------------|---|----------------|------------------|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF DEATH | | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| Theodore L. Horsey | | | 9-13 19 87 | | | 9-17 19 87 | | | 5:45 P | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | |
| M | N | 5-15-30 | 57 YRS. | | | M.D. | | | U.S.A. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | 13. STREET ADDRESS | | |
| Baltimore | | | 1829 N. Broadway | | | LABOR | | | | | | 1829 N. Broadway | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| Theodore L. Horsey | | | Blance Hicks | | | NO | | | 230-24-4982 | | | Melvin Horsey | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | |
| | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I am in charge of the remains described above, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> | | | | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | | | | |
| M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | |
| DATE SIGNED 9-18-87 | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (CITY OR TOWN) | | | 23e. COUNTY | | |
| | | | 9/22/87 | | | BALTO. Cem. | | | BALTO. | | | MD. | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | |
| Belts Funeral Home 1129 N. Caroline | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | | | |
| SEP 22 1987 | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |
| Julia Darden-Randall | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THE DEATH CERTIFICATE, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a necropsy performed.

Item 5,6 Film G631 9-14-87 SB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY M. Horton | | 2a. DATE OF DEATH MONTH DAY YEAR 9 4 87 | | 2b. HOUR 2:10 P.M. | |
| 3. SEX m | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 1-28-1923 1/28/19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 64 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore, MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Horton | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie White | | 13e. STREET ADDRESS, ZIP CODE 5518 Rubin Ave 21215 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 247-202491 | | 17. INFORMANT ADDRESS 5518 Rubin Ave. Bal MD 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>VENTRICULAR TACHYCARDIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>SEPT 9 1987</u> to <u>SEPT 9 1987</u> , that (i) (we) lost <u>P.A.</u> above, (i) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Fred B. Sunness, MD | | | | 22c. DATE SIGNED 9/4/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRED B. SUNNESS, MD | | | | 22e. ADDRESS SINAI HOSP OF BALTIMORE | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/10/87 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co MD | | 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 09 1987 | | | | 25b. REGISTRAR'S SIGNATURE John A. ... | |

BP

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065726 SEP 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) LESTER NMI HORTON JR | | | 2a. DATE OF DEATH MONTH 0 DAY 26 YEAR 87 | | | 2b. HOUR 3:28 PM | | | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH 2 DAY 12 YEAR 56 | | 6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | 7. IF UNDER 24 HRS HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE D.C. 13c. COUNTY N | | 13c. CITY OR TOWN WASHINGTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 706 FOSTER ST 20019 | | | | | |
| 14. FATHER'S NAME FIRST LESTER MIDDLE NMI LAST HORTON SR | | 15. MOTHER'S MAIDEN NAME FIRST JOSEPHINE MIDDLE HARRIS LAST HARRIS | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown | | 16b. SOCIAL SECURITY NO. 238-96-1429 | | 17. INFORMANT ADDRESS Lester Horton Sr. Father 130 Irvington St. S. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PCP pneumonia, renal failure | | | | | | | | | | 1 week | |
| DUE TO, OR AS A CONSEQUENCE OF (c) AIDS | | | | | | | | | | 1 week | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 19, 1987 to August 26, 1987 that (I) (we) last saw the deceased alive on August 26, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Pamela J Amelung | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 8/26/87 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pamela J Amelung | | | | | | 22e. ADDRESS 225 Greene St Baltimore MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPRINT) Burial | | 23b. DATE 01 Sept. 87 | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | 23d. LOCATION Cemetery Suitland, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Frazier's Funeral Home 389 Rhode Island Avenue, N.W. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1987 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SEP 16 1967

065129 SEP 10 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 5 7 7 9

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>CARLTON</u> MIDDLE: <u>THOMAS</u> LAST: <u>HOWARD</u> | | | 2a. DATE OF DEATH MONTH: <u>9</u> DAY: <u>10</u> YEAR: <u>1987</u> | | 2b. HOUR <u>6¹⁵</u> P.M. | | | | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>Caucasian</u> | | 5. DATE OF BIRTH MONTH: <u>4</u> DAY: <u>09</u> YEAR: <u>27</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>60</u> YRS. | | 7. IF UNDER 1 YEAR MONTHS: _____ DAYS: _____ | | 8. IF UNDER 24 HRS. HOURS: _____ MIN.: _____ | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE City</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>South Baltimore General Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>TRANSPORTATION</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>TRANSPORTATION</u> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: <u>MARYLAND</u> 13b. COUNTY: <u>-----</u> 13c. CITY OR TOWN: <u>Baltimore</u> | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE <u>617 E. Clement St. Balto Md 21230</u> | | | |
| 14. FATHER'S NAME FIRST: <u>CLAUDE</u> MIDDLE: <u>C.</u> LAST: <u>HOWARD</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST: <u>ELSIE</u> MIDDLE: <u>R.</u> LAST: <u>HUGHES</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u> | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>with Korea 219-18-7950</u> | | 17. INFORMANT <u>KEVIN HOWARD</u> | | | | ADDRESS <u>7264 Candle Shores Ct, Columbia Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>HEPATIC cirrhosis / gastrointestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>SEPT 7</u> 19 <u>87</u> , to <u>SEPT 7</u> 19 <u>87</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>SEPT 7</u> 19 <u>87</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>N. F. MUSSO, MD</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>9/7/87</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>N. F. MUSSO</u> | | | | | | 22e. ADDRESS <u>3001 South Hanover St. Balt., MD.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>9/10/87</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Crownsville, Vet, Ct.</u> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Crownsville, Md.</u> | | | |
| 24. FUNERAL DIRECTOR NAME: <u>McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 09 1987</u> | | 25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Parker</u> | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

062152 SEP 10 61

05:00

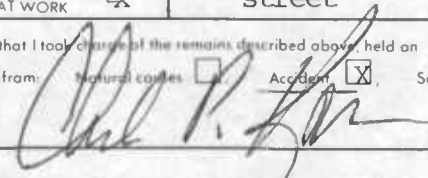
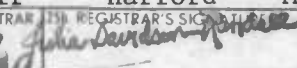
SEP 08 1961

64986 SEP-9 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|--|--|---|--|---|--|--------------------------|--|---|--|---|--|--|--|
| DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 7a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 7b. HOUR | |
| Timothy | | E. | | Howell | | | | 9-4- | | 19 | | 87 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | White | July 29, 1959 | | 28 YRS. | | | | | | 9-4 | | 19 | | 87 | | 2:49A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | MD | |
| Maryland | | USA | | | | Baltimore City | | | | | | | | | | | |
| 11. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | University Hospital | | Chef | | Marriott | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1118 Cedarcroft Rd. | | 21239 | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | | | |
| James | | A. | | Howell | | Marcelene | | | | | | Roberts | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| | | 212-70-0870 | | James A. Howell | | 1118 Cedarcroft Rd. | | 21239 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Multiple injuries</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| | | | | 1:45AM 9-4-1987 | | | | Driver in motorcycle/fixed object collision | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | |
| | | | | street | | | | Jones Falls Expressway (NB) at 12.9 mile mark | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | Baltimore City, MD | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | |
|  | | | | M.D. Assistant | | | | | | | | | | 9-4-87 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| Charles P. Kokes, M.D. | | | | 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | |
| Burial | | | | 9/8/87 | | | | Bel Air Memorial Grdns. | | | | Bel Air Harford Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| NAME | | | | ADDRESS | | | | SEPO 8 1987 | | | |  | | | | | |
| Mitchell-Wiedefeld Home, Inc., 6500 York Rd. | | | | Balto., Md. 21212 | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 1001. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07-84
25M

BP
DHMH - 17
(VR A15 ME (5))

04000 SEP-01

SEP 08 1992

065133 SEP 10 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2578

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|--|--|--|--|--------------------------|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| John | | J. | | Howard | | | | 9 | | 5 | | 19 | | 87 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | White | Jan. 7, 1964 | | 23 YRS. | | | | | | 9 | | 5 | | 19 | | 87 | | 9:15 P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | MD | |
| Maryland | | United States | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | | | | |
| 11. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | University Hospital | | Auto Mechanic | | Garage | | | | | | | | | | | | | |
| 10. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| Maryland | | Anne Arundel | | Pasadena | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 525 Sylvview Dr. | | 21122 | | | | | | | | | |
| FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | | | |
| James | | A. | | Howard, Sr. | | Hilda | | A. | | Kroschinsky | | | | | | | | | |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 14b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | 212 92 1980 | | James A. Howard, Sr. | | (Same as 13a-e) | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 8199 | | Multiple injuries | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | P.M. 8 24 19 87 | | Motorcycle accident | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| | | | | | | A.A. | | MD. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: | | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | Assistant | | 9/6/87 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | BALTO. MD. | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | 111 Penn St. | | Balto. MD. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | | | | | | | | | |
| Burial | | Sept. 10, '87 | | Glen Haven Mem. Park | | Gen Burnie Anne Arundel | | MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| McCully Funeral Homes | | Pasadena, Maryland 21122 | | SEP 09 1987 | | Julia Davidson-Randall | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMM - 17
(VR A15 ME (5))

002133 SEP 10 87

NOTION



SEP 09 1987

B

65655 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--------------|--|--|---|------------------|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) 1- (JESSIE) 2- Jesse HUBBARD | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 7 19 87 MATED <input type="checkbox"/> 9 7 19 87 | | | | 2b. HOUR M 5:13 P 13 | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 5 27 38 | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 7 19 87 | | 7d. HOUR M 5:13 P 13 | |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) Badin N.C. | | 7b. CITIZEN OF WHAT COUNTRY? America | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Off. | | 12b. KIND OF BUSINESS OR INDUSTRY Security | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1439 Kitmore Rd. 21239 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jesse Hubbard | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Allen | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes US53330931 | | | | 16b. SOCIAL SECURITY NO. 237-58-0318 | | 17. INFORMANT ADDRESS Annie Hubbard 1439 Kitmore Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <i>Charles P. Kokes</i> | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 9-8-87 | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. | | | | ADDRESS 111 Penn St., Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-12-87 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forrest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Garrison Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Law Funeral Home | | | | ADDRESS 4611 Park Heights Ave | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1987 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | |

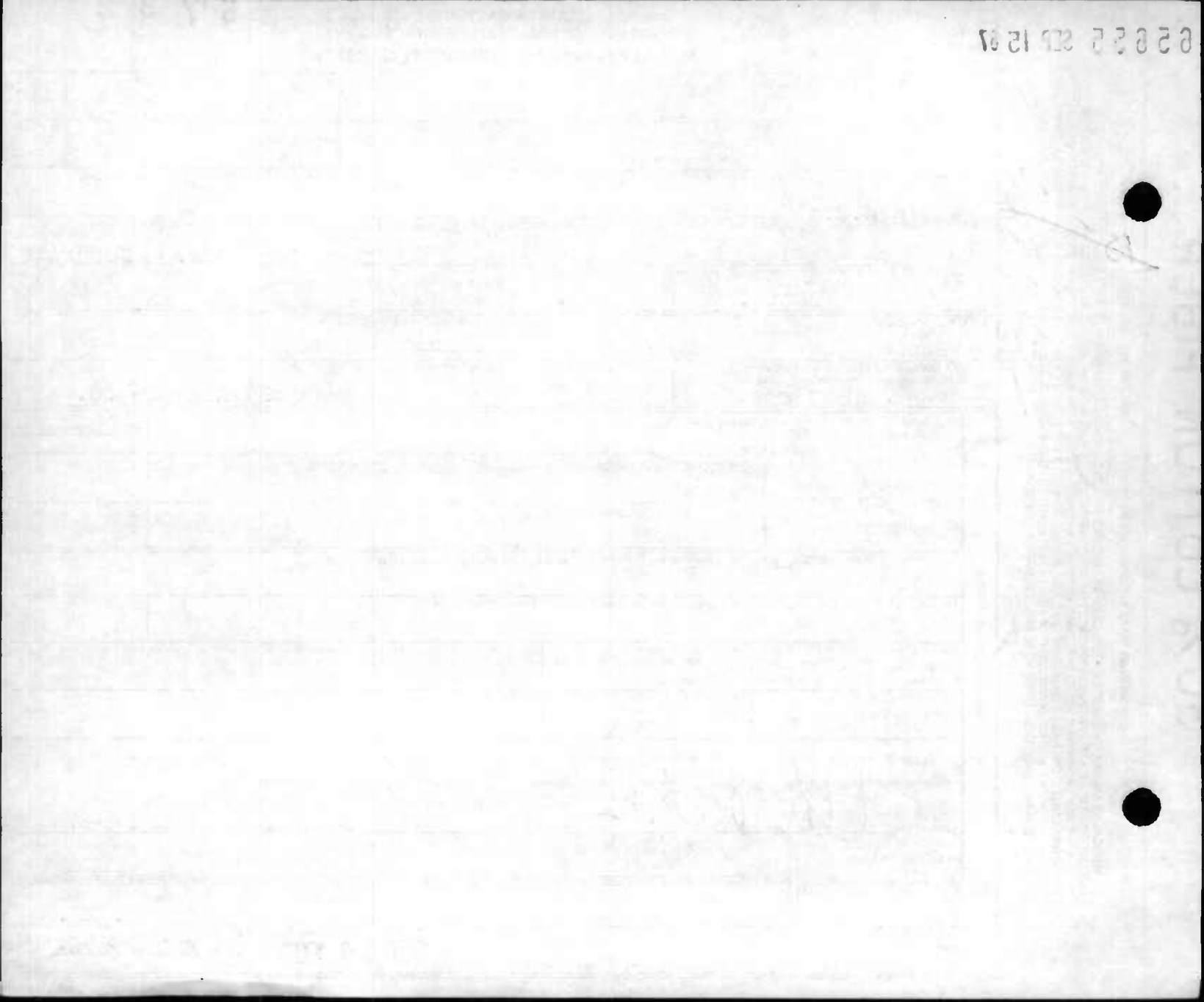
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ashley Huffines</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9 22 87</i> | | 2b. HOUR <i>2:40 PM</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>4 8 87</i> | |
| 6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>5 10 19</i> | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto City MD</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Balto</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Francis Scott Key Med Ctr</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE <i>490 Eastern Ave 21224</i> | | | |
| 13b. STATE <i>MD</i> | | 13c. COUNTY <i>13</i> | | 13d. CITY OR TOWN <i>City</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Eugene Huffines</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Georgina Reid</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>none</i> | | 17. INFORMANT ADDRESS <i>Eugene Huffines 1306 Chesapeake Ave. 21220</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>severe bronchopulmonary dysplasia</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>severe prematurity, ventilator dependence</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/22</i> 19 <i>87</i> to <i>9/22</i> 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>9/22</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Julia Gamella</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>9/22/87</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Julia Gamella</i> | | 22e. ADDRESS <i>490 Eastern Ave. Balto MD 21224</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>9/25/87</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Holly Hill Cemetery</i> | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Middle River Balto. Maryland</i> | | 24. FUNERAL DIRECTOR NAME ADDRESS <i>Connolly Funeral Home 300 Mace Ave. 21221</i> | | | |

SEP 29 1987

REGISTRAR'S SIGNATURE

0 8 5 1 0 0 SEP 30 01

99919 101100 X02

NO. 101100 X02

SEP 30 00

067403 OCT 1-87

Item 15 Film G632

FOR STATE REGISTRAR 10-2-87 I.J.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 2578

REG. NO.

| | | | | | | | | |
|--|--|---|---|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES ARTHUR HUGHES | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 28 87 | | | 2b. HOUR 2:40P | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 02 05 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, | | | MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Century Home, Inc. | | | 12a. USUAL OCCUPATION (TYPICAL WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Beth Steel | | |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 1908 Payson St. 21216 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas (Tom) Hughes | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Alice Hughes | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes ? | | 16b. SOCIAL SECURITY NO. 223-16-5045 | | 17. INFORMANT ADDRESS Annie Hughes 834 W. Coldspring Lane | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Glioblastoma Multiforme DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-25-87 to 9-28-87 , that (I) (we) last saw the deceased alive on 9-28-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-29-87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. NAIR, MD | | | | 22e. ADDRESS Solo York Road, Baltimore, MD 21212 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-3-87 | | 23c. NAME OF CEMETERY OR CREMATORY Garrison Forest | | 23d. LOCATION CITY OR TOWN COUNTY STATE Swains Mills, Md. | | |
| 24. FUNERAL DIRECTOR NAME James F. Morton | | | | 1701 Lauren St | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and place page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

088403 OCT-1 67

09 28 87 2:00P

HUGHES

ANTHONY

JAMES

Male

Black

09 28 87

09

Baltimore City

USA

Virginia

Beth Steel

Century Home, Inc.

Baltimore

1998 Payson St. 21212

Baltimore

MD

323-16-2042 Annie Hughes 830 W. Goldsboro Lane

Van



2042

067461 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/B4
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME FIRST MIDDLE LAST JONATHAN C. HUNT | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 29, 1987 | | 2b. HOUR P M 2:33 P M | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 5 24 86 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 1 YRS IF UNDER 1 YEAR MONTHS DAYS 4 IF UNDER 24 HRS HOURS MIN. 4 | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Md. | | | 13a. CITY OR TOWN Beltz Arundel Severna Park | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carroll W. Hunt Jr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Thomas | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Carroll W. Hunt Jr. 911 Old County Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypoglycemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>inability to absorb enterally, loss of venous access</u> 16 months APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 minutes 1 hour 11 hours | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <u>Insulin dependent diabetes</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>Sept 28</u> 19 <u>86</u> to <u>Sept 29</u> 19 <u>87</u> , that (I) <u>we</u> last saw the deceased alive on <u>Sept 29</u> 19 <u>87</u> , and that in (my) <u>hour</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Elizabeth Bernster</u> | | | | DEGREE MD | | 22c. DATE SIGNED 9/29 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Elizabeth Bernster</u> | | | | 22e. ADDRESS <u>600 W. Wolfe St. Bldg. 100-21205</u> <u>Johns Hopkins Hospital, Baltimore MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/2/87 | | 23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville Md. | |
| 24. FUNERAL DIRECTOR William Reese & Sons | | | | ADDRESS Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR OCT 01 1987 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial permit. Then please remove this page. Page 2 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial permit. Then please remove this page. Page 2 should be filled within 72 hours after death.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

16-5-730 124730

187 TAKEN

— 214 —

10701 1891

066142 SEP 18 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25786

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| FIRST MIDDLE LAST | | 9 15 87 | | 11 15 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| MALE | | WHITE | | MONTH DAY YEAR | |
| | | | | 11 28 20 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Maryland | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTO. CITY | | | | BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| BALTO. CITY | | UNIVERSITY OF MARYLAND | | Ret. Foreman | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | A.A. Co. | | Baltimore | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | Yes WW 2 | |
| Nolan J. Hurley | | Christina Frederick | | 16b. SOCIAL SECURITY NO. 214-01-8625 | |
| 17. INFORMANT | | ADDRESS | | 17b. STREET ADDRESS / ZIP CODE | |
| John M. Zivec | | Burnie, Md. 21061 | | 220 W. Meadow Rd., 21225 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. DATE OF OPERATION | | 20a. AUTOPSY? | |
| PART I. DEATH WAS CAUSED BY: | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PROB. MYOCARDIAL INFARCTION | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) DIABETES | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost | | | | | |
| saw the deceased above, (I) (we) (did) (did not) see the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| 22b. SIGNATURE | | 22c. ADDRESS | | 22d. DATE SIGNED | |
| HARRY CHEVALER | | 22 S. GREENE ST. 21201 | | 9/15/87 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS | | 22g. DATE SIGNED | |
| HARRY CHEVALER | | 22 S. GREENE ST. 21201 | | 9/15/87 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/18/87 | | Cedar Hill Cemetery | |
| 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| CITY OR TOWN COUNTY STATE | | SEP 17 1987 | | Julia Davidson-Randall | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | |
| NAME | | 237 E. Patapsco Ave., | | SEP 17 1987 | |
| McCully Funeral Homes Balto., Md. 21225 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked, item 18 should show any injury, or other traumatic event, the medical examiner must be notified at once.

088145 SEP 18 87

065912 SEP 17 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES JOSEPH HUSTER | | | 2a. DATE OF DEATH MONTH DAY YEAR 09/15/87 | | 2b. HOUR 12:50am |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 06/15/910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIREFIGHTER. | | 12b. KIND OF BUSINESS OR INDUSTRY Fire Dept. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Md Balto. | | 13c. CITY OR TOWN Catonsville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 2 Bristol Hill Ct. 21228 A4 |
| 14. FATHER'S NAME FIRST MIDDLE LAST William J. Huster | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara A. Gumpman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 216-01-5643 | | 17. INFORMANT ADDRESS Mary A. Huster 2 Bristol Hill Ct. A4 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Brainstem infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain Tumor</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>Aspiration pneumonitis</u> | | | | | |
| 19a. DATE OF OPERATION 9/4/87 + 9/6/87 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/3/87</u> , 19____, to <u>9/15/87</u> , 19____, that (I) (we) last saw the deceased alive on <u>9/14/87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Hochuli</u> | | DEGREE MD | | 22c. DATE SIGNED 9/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOCHULI | | 22e. ADDRESS 900 CATON AVE Balt, Md. 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/18/87 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland | | 23e. DATE REC'D. BY REGISTRAR SEP 16 1987 | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | ADDRESS 4107 WILKENS AVE. | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy (page 4) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 (a) is marked or item 18 (b) is marked or item 18 (c) is marked, the notified agent

002215 SEP 17 84



066143 SEP 18 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

(TYPE OR PRINT)

Lillian

Hyson

(HYSON)

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
9-12-87 2:40 PM

3. SEX

FEMALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH DAY YEAR
10 04 13

6. AGE (IN YEARS LAST BIRTHDAY)

73

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Baltimore, Md.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Deaton Hospital

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

DOMESTIC

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

ANNE ARUNDEL

13c. CITY OR TOWN

BURNIE

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

7459 CRILLEY RD

21061

14. FATHER'S NAME

FIRST MIDDLE LAST
CHARLES

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
LILLIAN M. SULLIVAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)
212-26-7575

17. INFORMANT

Admission

ADDRESS

Record

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cancer Breast & Mets

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (this hospital) attended the deceased from 9/13, 19 87, to 9/12, 19 87, that (we) lost
saw the deceased alive on 9/12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (s) (we) (did) (did not) view the body after death.

22b. SIGNATURE

J. Raymond Gladue, MD

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

9/15/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

J. RAYMOND GLADUE

22e. ADDRESS

611 S. CHARLES ST. BALTIMORE MD

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)
CREMATION

23b. DATE

SEPT. 14, 1987

23c. NAME OF CEMETERY OR CREMATORY

SECURITY PROCESS, INC.

23d. LOCATION

CITY OR TOWN COUNTY STATE
CATONSVILLE BALTIMORE MD

24. FUNERAL DIRECTOR

NAME
McCully Funeral Homes

3204 MOUNTAIN RD.

PASADENA, MD 21122

25a. DATE REC'D. BY REGISTRAR

SEP 17 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

062143 SEP 18 37

066186 SEP 18 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 2578

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WINFRED Howard INGRAM | | | 2a. DATE OF DEATH MONTH 09 DAY 15 YEAR 87 | | | 2b. HOUR 328 AM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 12 DAY 07 YEAR 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Boeing Aircraft | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE RT 4, Box 360 21740 | |
| 14. FATHER'S NAME FIRST HOWARD MIDDLE INGRAM LAST INGRAM | | | | 15. MOTHER'S MAIDEN NAME FIRST MABEL MIDDLE STICKEL LAST STICKEL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN | | | | 16b. SOCIAL SECURITY NO. 217-10-2788 | | 17. INFORMANT Bernadine Ingram ADDRESS Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 10 min. | | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Sepsis | | | | | | | | | 3 weeks | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Failure | | | | | | | | | > 3 weeks | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION 7/4/87 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Disease | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 9/15 19 87 , to 9/15 19 87 , that (1) (we) last saw the deceased alive on 9/15 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Jon Preston | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/15/87 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon PRESTON | | | | | | 22e. ADDRESS Univ. of Maryland Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE Sept. 18, 1987 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | 25a. DATE REC'D BY REGISTRAR SEP 18 1987 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Landree | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

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